

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

7 5 2 5

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE KNOWN
OF
ESTI-
DEATH MATED

MONTH DAY YEAR HOUR

6/ 28/ 1987

M

Meredith Reginald Anthony, Sr.

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR6. AGE (YEARS
LAST BIRTHDAY)7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN7a. BIRTHPLACE
(STATE OR
FOREIGN COUNTRY)

Wash., D.C.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED
WIDOWEDNEVER MARRIED
DIVORCED2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR HOUR

6/ 28/ 1987

M

4:30 P.M.

9 BALTIMORE CITY OR COUNTY OF DEATH

Howard County,

MD.

10. CITY OR TOWN OF DEATH

Columbia

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

5662 Stevens Forest

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS
OR INDUSTRY

21045

13a. STATE

Maryland

13b. COUNTY

Howard

13c. CITY OR TOWN

Columbia

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS

5662 Stevens Forest Road

14. FATHER'S NAME

Albert Anthony

FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME

Mattie Russell

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

yes

(IF YES, GIVE WAR OR DATES)

Navy

16b. SOCIAL SECURITY NO.

579 38 2721

17. INFORMANT

4906 8th Street, N.E.

ADDRESS

Meredith R. Anthony, Jr.-son

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hypertensive Cardiovascular Disease & Chronic Renal Failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHConditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

{

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

P.M.

19

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN

COUNTY STATE

CITY

COUNTY STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy Inspection Inquiry death resulted from: Natural causes Accidental Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE
SIGNED 6/30/87EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS 111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION
CITY OR TOWN

COUNTY STATE

Burial

July 3, 1987

Lined In Memorial

Cemetery Suitland, Md.

24. FUNERAL DIRECTOR

NAME

Stewart

Funeral Home

4001 Benning Road, NE

DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Dennis F. Smyth

6/ 09/ 1987

John F. Anderson, Esq.

100% GO 4.00 - 100%

999999 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

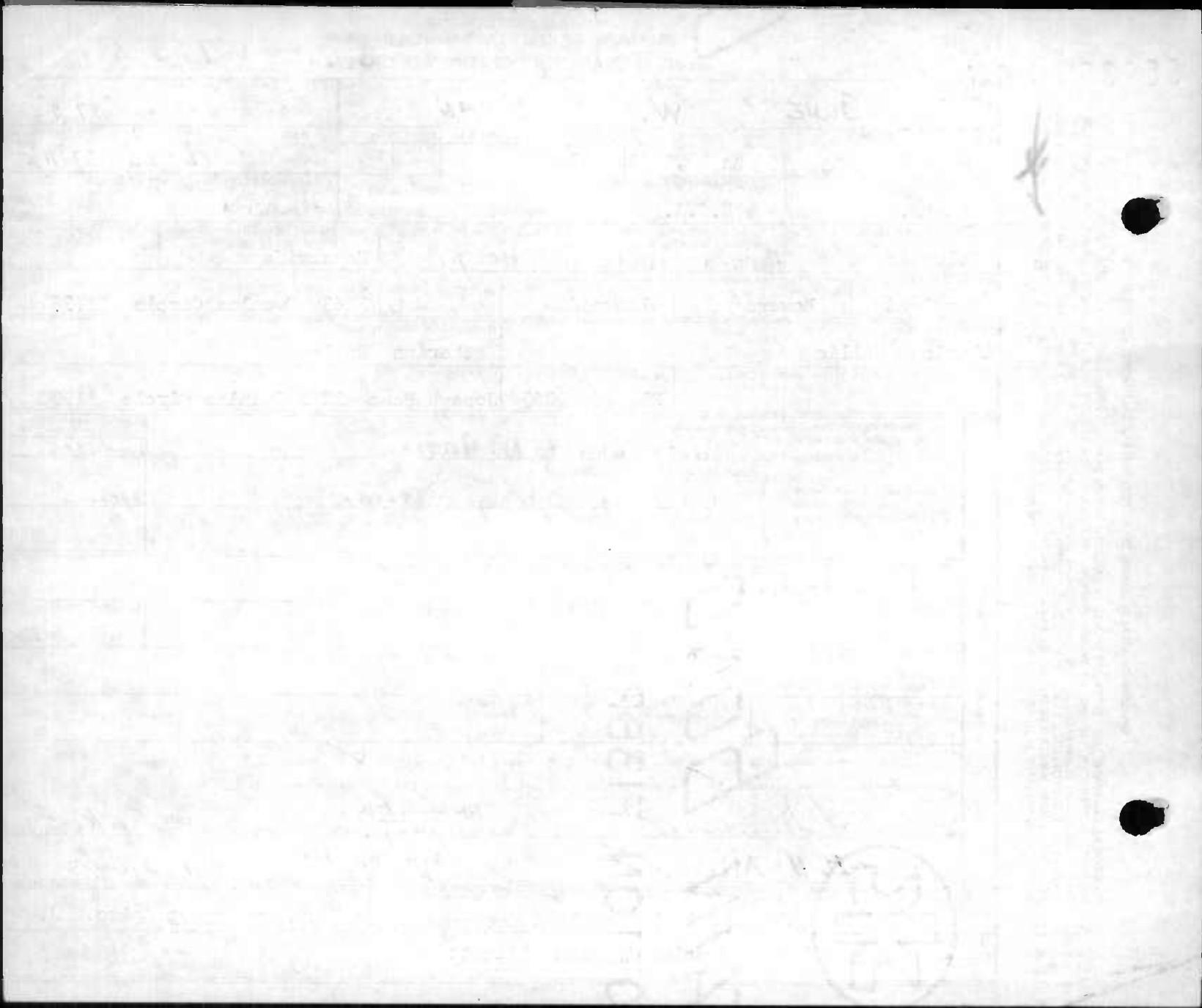
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
FOR STATE REGISTRAR			87 17526							
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mandley	MIDDLE W.	LAST Austin	2a. DATE OF DEATH MONDAY JUN 6 1987		MONTH JUN	DAY 6	AM 4P	2b. HOUR 4P M
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONDAY APRIL 13, 1903		YEAR 1903	6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County				
10. CITY OR TOWN OF DEATH Highland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13078 St. Patricks Court 20777		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Lt. Col.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force				
13a. STATE Florida		13b. COUNTY Pinellas		13c. CITY OR TOWN Palm Harbor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 240 Timberlane Drive 33563		
FATHER'S NAME Edward		MIDDLE R.	LAST Austin	15. MOTHER'S MAIDEN NAME Cora		16. SOCIAL SECURITY NO. 082-32-0728		17. INFORMANT Anne A. Jennings (daughter) 13078 St. Patricks Ct. Highland, Md. 20777		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____ DUE TO, OR AS A CONSEQUENCE OF								
		(c) _____ DUE TO, OR AS A CONSEQUENCE OF								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cirrhotic liver disease / Cirrhotic obstructive pulmonary disease</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/15/87 to 6/19/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <i>Edward Jackson, M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 6/4/87				
22e. PHYSICIAN'S NAME (THE DECEASED)		22f. ADDRESS 554 New Pages Rd, Chantilly, Virginia								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/3/87		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION Alexandria, Virginia				
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR JUN 8 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Darden-Readless</i>				

056035 JUN - 987
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be left within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed and signed by a physician before the certificate can be issued.

DHMH - 16 50M 4/83
 (VRA 15, 4)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM. 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17521			
1- STATE REGISTRAR			FIRST JUNE			MIDDLE W.			LAST BEAN			2a DATE KNOWN OF ESTI- DEATH MATED			
(TYPE OR PRINT)												<input checked="" type="checkbox"/>	MONTH	DAY	YEAR
3. SEX F			4 RACE Cauca.			5. DATE OF BIRTH MONTH DAY YEAR June 28, 1939			6 AGE (IN YEARS LAST BIRTHDAY) 47 yrs.			IF UNDER 1 YR. IF UNDER 24 HRS.			
												MONTHS	DAYS	HOURS	MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD			12b HOUR 44 M			
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County Gen. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Howqrdr			13c. CITY OR TOWN Glenwood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3263 Gwenlee Circle 21738			
14. FATHER'S NAME FIRST Charles WALLIS			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Katherine Kelly			MIDDLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 36 5865			17. INFORMANT Joseph Bean			ADDRESS 3263 Gwenlee Circle 21738						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN						
									COUNTY						
									STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												DATE SIGNED 6/06/87			
ACTUAL SIGNATURE B.H. Minchew						M.D. <i>Minchew</i>			MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) B.H. Minchew						ADDRESS <i>N. Ridge Rd., Ellicott City, Md. 21043</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 9, 1987			23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.			23d. LOCATION CITY OR TOWN Garrison Forest Balto. Md.						
24. FUNERAL DIRECTOR Harry H Witzke 4112 Old Columbia Pike Ellicott City						25a. DATE REC'D. BY REGISTRAR JUN 8 1987			25b. REGISTRAR'S SIGNATURE Julia Sonder-Randall						
NAME															





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical statement must be filed along with the certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 17528			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
MARY I BECKLES						6-21-87						10:45 PM	
3. SEX F			4. RACE B	5. DATE OF BIRTH MONTH 12 DAY 15 YEAR 01			6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GUYANA, S. AMERICA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.				
10. CITY OR TOWN OF DEATH COLUMBIA, MD.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIEN NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE NEW YORK			13b. COUNTY CORAM			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 116 SEQUORIA DR. 21277				
14. FATHER'S NAME JACOB			15. MOTHER'S MAIDEN NAME Henery			16. SOCIAL SECURITY NO. 084-22-1053			17. INFORMANT Frank Beckles-13820 Piscataway Dr.				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			RESPIRATORY ARREST										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE										
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ORGANIC BRAIN SYNDROME													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) this hospital attended the deceased from 19 86 to 6 19 87, that (1) we last saw the deceased alive above, (1) we did not view the body after death.													
22b. SIGNATURE <i>Evelyn Jackson, MD</i>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 6/24/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVELYN JACKSON, MD		22e. ADDRESS 5540 NEW OAKS RD. CLARKSVILLE MD 21029											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/27/87		23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		23d. LOCATION CITY OR TOWN Washington DC		23e. COUNTY STATE					
24. FUNERAL DIRECTOR NAME SAM Butter Funeral Service		ADDRESS 716 Kennedy Street			25a. DATE REC'D. BY REGISTRAR JUN 29 1987		25b. REGISTRAR'S SIGNATURE <i>John B. Baker</i>						

BP _____
CHMH 10-NOM 7/84
(RA 2-4)

999999

17258

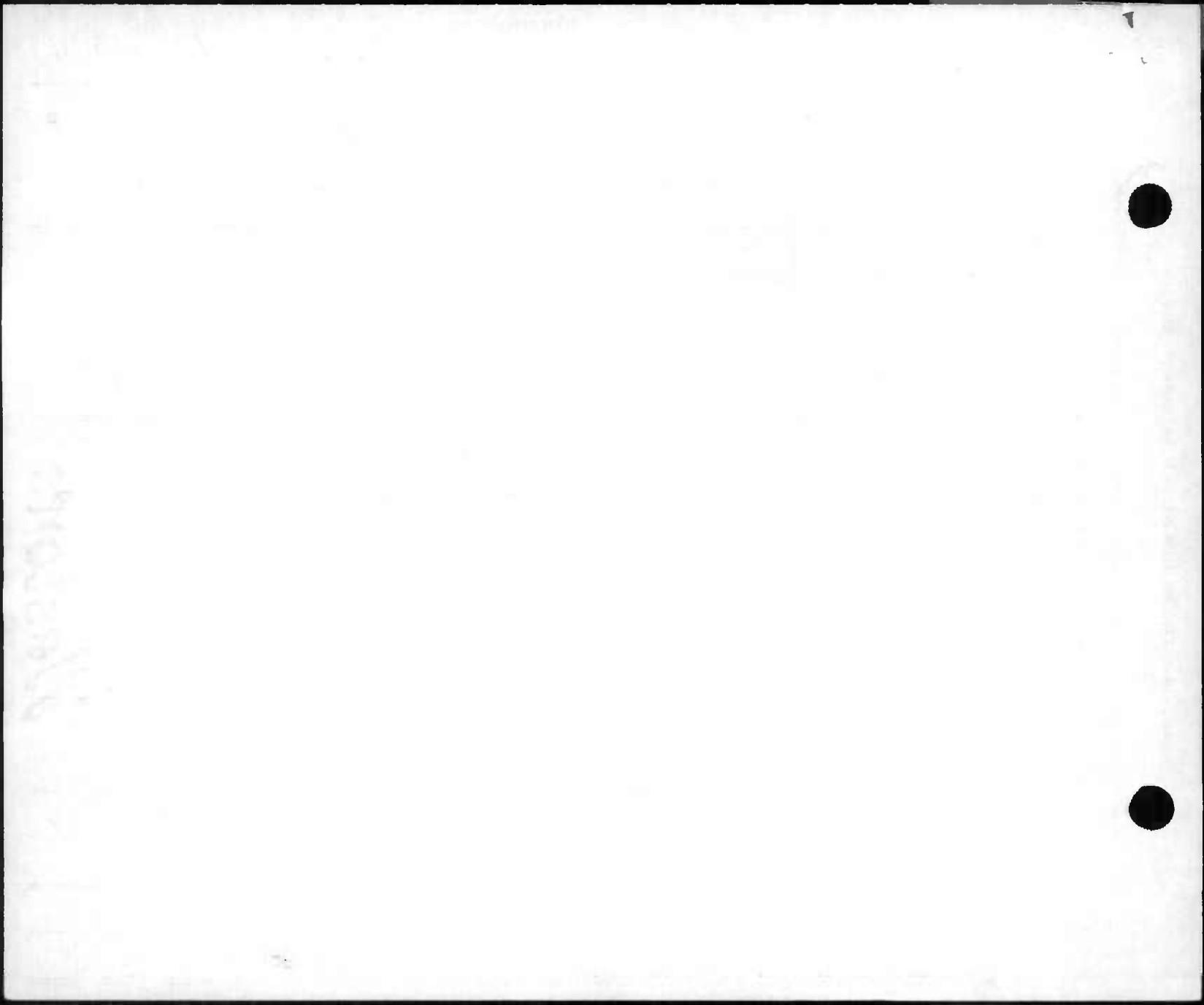
17258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	7	1	7	5	2	9
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
James			V.		Boos	June 8 1987						12:10 AM						
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male			White		July 12 1928			58 yrs										
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Oregon			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard County										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Columbia			5006 Eliots Oak Road			Research Planner			Federal Highway Admin.									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland			Howard		Columbia						5006 Eliots Oak Rd. 21044							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME												
John					Boos	Veronica												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS									
Yes			KOREAN 539-22-2238			Brenda Boos			same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic adenocarcinoma of colon</i>																		
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 years</i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)												
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>72</i> , to <i>June</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>11-17</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>6-9-87</i>						
22b. SIGNATURE <i>Dawn A Moore MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dawn A Moore</i>			22e. ADDRESS <i>2 Knoll North, Columbia, MD</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 10, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Westview Crematory			23d. LOCATION CITY OR TOWN Westview			COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Letroy M. & Russell C. Witzke Funeral Home P.A. ADDRESS 5555 Twin Knolls Rd. Columbia, Md. 21045						25a. DATE REC'D. BY REGISTRAR JUN 12 1987			25b. REGISTRAR'S SIGNATURE <i>John L. Witzke</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carbon copies made, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 may be used in conjunction with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 871753			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
			ERNEST E. CARR, Jr.						June		4, 1987		M		
3. SEX MALE			4. RACE White			5. DATE OF BIRTH MARCH 5, 1917			6. AGE 70 yrs.			IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY, MD.						
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3436 Rollingview Court						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
13a. STATE Md.			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3436 Rollinview Ct., 21043			
14. FATHER'S NAME FIRST Ernest			MIDDLE E.			LAST Carr, Sr.			15. MOTHER'S MAIDEN NAME FIRST Barbara			MIDDLE LAST Eber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17. INFORMANT ADDRESS Virginia Carr 3436 Rollingview Cr., Ellic. City									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular fibrillation												years.			
{ DUE TO, OR AS CONSEQUENCE OF (c) Atherosclerotic cardiovascular sys disease												years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Carcinoma of tongue															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from Feb 20, 1986 , to DATE , 19_____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 27 1987 , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did not view the body after death.															
22b. SIGNATURE Willie Barnes			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6-4-87						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM PARNES			22f. ADDRESS 11085 LITTLE PATUXENT Pkwy Columbia, MD 21044												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/6/87			23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn			23d. LOCATION CITY OR TOWN Marriottsville Ho.			23e. COUNTY Md.			
24. FUNERAL DIRECTOR HARRY H. WITZKE & FAMILY FUNERAL HOME, INC.			25a. DATE REC'D. BY REGISTRAR JUN 8 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandale									

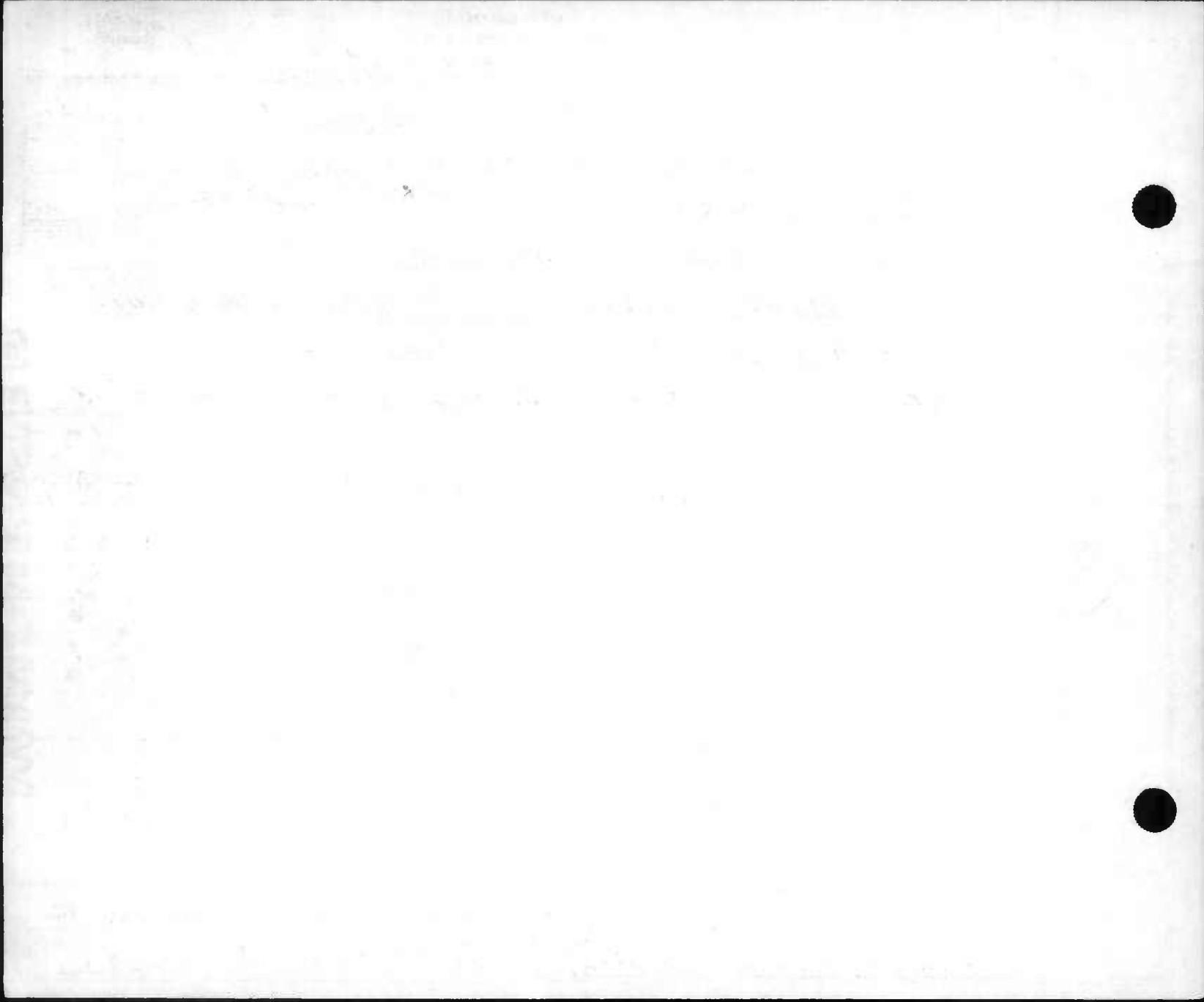
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. It can then be removed carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 17532			
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIAM	MIDDLE COLLINS	LAST	6. DATE OF DEATH MONTH DAY YEAR			7. HOUR						
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD CO. County			10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY HOWARD	13c. CITY OR TOWN LAUREL	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1885 Harmony Lane 20707									
14. FATHER'S NAME FIRST Arthur			MIDDLE Collins	LAST	15. MOTHER'S MAIDEN NAME FIRST Laura			MIDDLE Green	LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	16c. INFORMANT ADDRESS Bertha Brown (Friend) same #5 #13											
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio respiratory Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) Acute Myocardial Infarction												4 days			
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cardiac Arrhythmias & Atherosclerotic Cardiovascular Disease															
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6/8/87 to 6/9/87 , that (I) (we) last saw the deceased alive on 6/8/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE 			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/9/87						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-13-87			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery			23d. LOCATION CITY OR TOWN Laurel, A. Arundel, MD						
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. Washington Rockville, MD20850			25a. REC'D. BY REGISTRAR JUN 14 1987			25b. REGISTRAR'S SIGNATURE John D. Wilson, R.D.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be attached.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 17533
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Catherine</i>	MIDDLE <i></i>	LAST <i>Dixon</i>	2a. DATE OF DEATH MONTH <i>July</i>			DAY <i>17</i>	YEAR <i>1987</i>	2b. HOUR <i>5:45 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>2</i>			DAY <i>11</i>	YEAR <i>05</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>82</i>			IF UNDER 24 HRS MONTHS <i>0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard Co Mo</i>				
10. CITY OR TOWN OF DEATH <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard Co Gen Hosp</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baldo</i>		13c. CITY OR TOWN <i>Oxon Hill</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>20732</i>			
14. FATHER'S NAME FIRST <i>Harkless</i>		MIDDLE <i>Rice</i>	LAST <i></i>	15. MOTHER'S M AIDEN NAME FIRST <i>Mabel</i>			MIDDLE <i>Pitt</i>	LAST <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214405591</i>			17. INFORMANT <i>Mr. Monroe Taylor</i>			ADDRESS <i>71216</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Anesthetic failure</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>None</i>												
19a. DATE OF OPERATION <i>7/6/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i></i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i></i>			21f. LOCATION STREET <i></i>			CITY OR TOWN <i></i>	COUNTY <i></i>	STATE <i></i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>7/6/87</i> to <i>7/6/87</i> , that (I) (we) last saw the deceased alive on <i>7/6/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John Jackson</i>												
22c. DEGREE <i></i>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gregory L. Rice</i>		22e. ADDRESS <i>1005 Little Patuxent Dr.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED <i>6/20/87</i>				
23a. BURIAL, CREMATION, REMOVAL (SAYING) <i>Burial</i>		23b. DATE <i>7-6-87</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Arbutus Memorial Burial Co</i>			23d. LOCATION CITY OR TOWN <i>Baltimore</i>				
24. FUNERAL DIRECTOR NAME <i>Gregory L. Rice</i>		ADDRESS <i>22224 North Ave</i>			25a. DATE REC'D. BY REGISTRAR <i>JUL 07 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia London-Randall</i>				

52. *Asperula odorata*

10.10.10.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN: The

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial container panel. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hyg and the Police to burial, cremation, or removal.

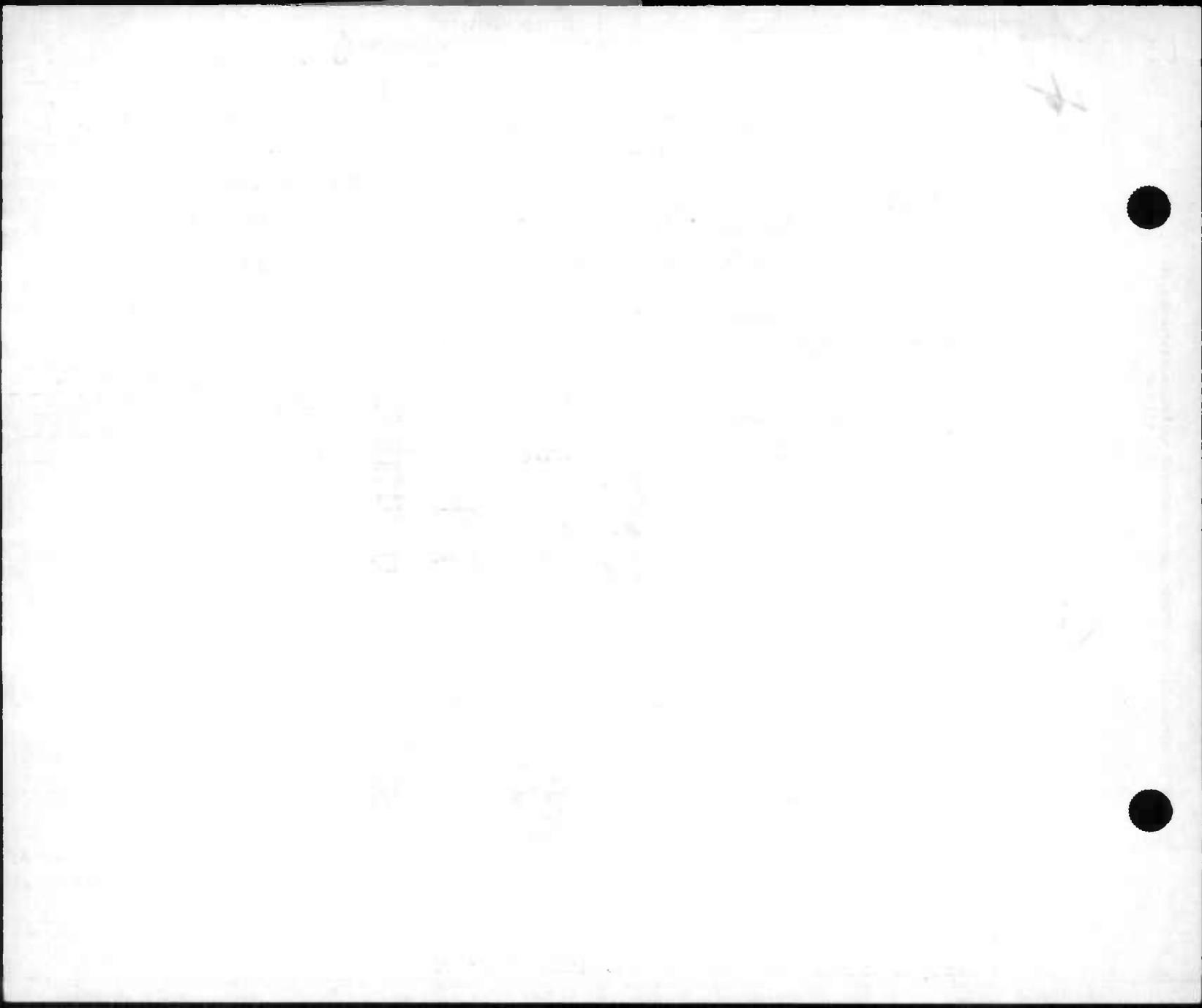
IMPORTANT: If Item 27 is marked or Item 18 contains any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 17534
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
DOROTHY (Leonard)					ELLIIS	6	29	87	11 ¹⁰ AM				
3. SEX	F Female	4 RACE	C White	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	IF UNDER 24 HRS		
				63	17	93	94	YEARS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)	New York	7b. CITIZEN OF WHAT COUNTRY?	U.S.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					HOWARD MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
Woodbine	15648 Union Chapel Road					Housewife							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a STATE	mo	13b COUNTY	HOWARD	13c. CITY OR TOWN	WOODBINE	13d. INSIDE CITY LIMITS?	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE	21797			
14. FATHER'S NAME Arthur ^{1ST} G Leonard MIDDLE LAST				15. MOTHER'S MAIDEN NAME Mary J Ashley									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
No			001 36 1410			Mary Jane Ellis			Woodbine Md. 15648 Union Chapel Rd 21797				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
REFUGEE													
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			P.M.	19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>6/20</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.				JAN 19 83		to JUNE 19 87							
22b SIGNATURE	DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
<u>Evelyn Jackson</u>										6/29/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS			22f			22g			22h			
Evelyn Jackson	5540 TEN OAKS RD, CLARKSVILLE, MD			22f			22g			22h			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d LOCATION										
Burial	July 1, 1987	Little Woods Cemetery	Wayne										
24 FUNERAL DIRECTOR NAME	ADDRESS	City	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE									
Harry H Witzke 4112 Old Columbia Pike Ellicott		JUL 1 1987	JUL 1 1987	Julia Leardon-Landau									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please attach carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8717535				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
HELEN IRENE FEARING						JUNE 20, 1987						5:05 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		WHITE		MONT DAY YEAR JULY 4, 1907			79			YEARS	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HOWARD COUNTY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
ELLIOTT CITY		4445 STONECREST DRIVE		PHYSICIAN			OB/GYN									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
MARYLAND		HOWARD		ELLIOTT CITY			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4445 STONECREST DR. 21043						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
WILLIAM		EDWARD		MAGINNIS	MABEL			LEE		DONOHUE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT			16d. ADDRESS									
No		216-46-3501		WILLIAM L. FEARING, M.D.			4445 STONECREST DR. ELLIOTT CITY, MD. 21043									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												March 1987				
DUE TO, OR AS A CONSEQUENCE OF (b) Stroke																
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease												10 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 14</u> , 19 <u>87</u> , to <u>Present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>June 14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 6-23-87				
22b. SIGNATURE <i>Wilfred H. Townshend Jr.</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 14 East Eager Street - Balto. Md. 21202									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2 JULY 87		23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHN'S CEMETERY			23d. LOCATION CITY OR TOWN ELLIOTT CITY			COUNTY HOWARD		STATE MD				
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS BOX 268 ELLIOTT CITY, MD 21043		25a. DATE REC'D. BY REGISTRAR JUN 25 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Raddees</i>									

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING IN PENCIL" IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 7 5 3 6											
1- STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT)					FIRST		MIDDLE		LAST		2a. DATE KNOWN X OF ESTI- DEATH MATED		MONTH DAY YEAR	2b. HOUR					
		Bernard Leroy Gilbert											<input checked="" type="checkbox"/>		6/8/1987	M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. DATE MONTH DAY YEAR		2e. HOUR 4:45 a.m.					
Male		Caucasian		July 1, 1936		50						<input checked="" type="checkbox"/>		6/8/1987		M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County													
New York		USA																			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
		Rt. 95 between Rts. 216 & 32										Truck Driver -Ryder Leasing		999999							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD.											
Virginia		Henrico		Richmond				3215 Williamsburg Rd.													
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST											
Charles Gilbert						Alys Neamon															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
yes		(if yes, give war or dates)		Korean		105-28-7936		JoAnn Gilbert-3215 Williamsburg Rd., Richmond, VA 23231													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal Injuries & Smoke Inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? XX 6/8/1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) subject driver of tractor trailer/truck impact															
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET CITY OR TOWN Rt. 95 between Rts. 216-32, Howard County, Md.			CITY OR TOWN COUNTY STATE												
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>						and in my opinion												
ACTUAL SIGNATURE Dennis F. Smyth, M.D.			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER			DATE SIGNED 6/8/87												
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.			ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/11/87			23c. NAME OF CEMETERY OR CREMATORIAL Washington Memorial Pk.			23d. LOCATION CITY OR TOWN Sandston, Virginia			COUNTY STATE									
24. FUNERAL DIRECTOR NAME Lynette R. Spence			ADDRESS 4650 S. Laburnum Ave., Rich, Va.			25a. DATE REC'D. BY REGISTRAR JUN 16 1987			25b. REGISTRAR'S SIGNATURE Julia Seiden-Randall												

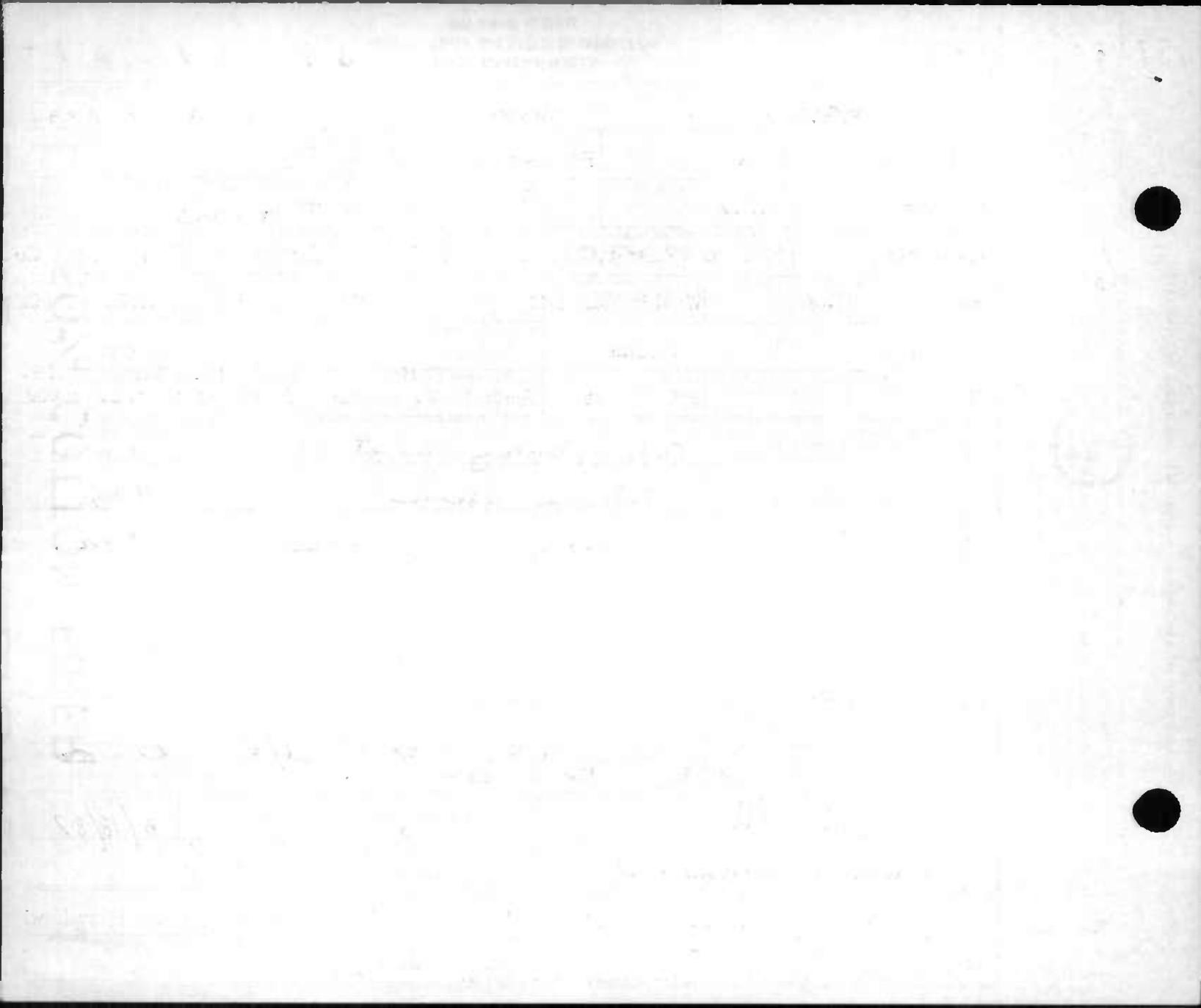
executed within 24 hours after death. Page 4 may be

executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove entire certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or if the medical examiner has not signed this certificate, it must be filed with the medical examiner's office.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8717537	REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
DeLacy			J.		Heeter				6	18	87	11:40 A.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH February 25, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 80			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE Indiana			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County			IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Columbia			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter			12b. KIND OF BUSINESS OR INDUSTRY Dyson Meat Co.			MD.		
13a. STATE None			13b. COUNTY None			14. CITY OR TOWN Washington D.C.			14d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14e. STREET ADDRESS / ZIP CODE 1217 Orren Street, N.E., 20002		
14. FATHER'S NAME Amasa			15. MOTHER'S MAIDEN NAME Alta			16. SOCIAL SECURITY NO. 329-07-6987			17. INFORMANT (Wife) Amanda V. Heeter			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest			DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary edema			DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/18 , 19 57 , to 6/18 , 19 57 , that he lost soul the deceased alive on 6/18 , 19 57 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Charles E. Shedd MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/18/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Shedd MD			22e. ADDRESS 11055 Little Patuxent Parkway											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 06/22/87			23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			23e. COUNTY STATE P.G. Maryland		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.			ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781			25a. DATE REC'D. BY REGISTRAR JUN 23 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Johnson</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the certificate returned to the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8717538		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR		
Arthur			L:		Herbert	6/8/87			6	4	87	6:45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			16. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M		Black		MONTH	DAY	YEAR	91			YRS	MONTHS	DAYS	HOURS	MIN.
6/8/87		USA		6/2/96			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8.			Howard Co.			MD.				
Virginia		USA												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12b. KIND OF BUSINESS OR INDUSTRY		
Columbia		Lorien Nursing Home										retired		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ZIP CODE				
MD		Howard		Columbia						6334 Cedar Lane 21044				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME									
Joseph				Herbert	Rebecca									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES		WWI		212-01-6296			Virginia Lewis			2007 Bryant Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure														
DUE TO, OR AS A CONSEQUENCE OF (c) Adolescent heart disease														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Valvular heart disease peripheral vascular disease														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19/29														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/1/91 19 84 to 6/4/87 19 87, that (I) (we) last saw the deceased alive on 6/4/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>John S. Smith</i>		22c. DEGREE MD			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John S. Smith</i>		22f. ADDRESS 5210 York Rd Baltimore MD 21212												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/87		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Nat. Cemetery			23d. LOCATION CITY/TOWN Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME Wm C March F/H West		ADDRESS 4300 Wabash Ave.		25. DATE REC'D. BY REGISTRAR JUN 8 1987			25. REGISTRAR'S SIGNATURE Julia Sanderson-Lindner							
BP														
DHMH - 16 60M 7/84 (VRA 15, 4)														



LONG COTTON CEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8717539					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			William George Laricos									6 11 87			8:45 M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Male			White			3 4 09			78			YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Elliot City, Md.			Howard Co., MD.					
New York			USA														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Ellicott City			3408 Rogers Ave			Retired			Civil Defense								
13a. STATE Md			13b. COUNTY Howard			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3408 Rogers Ave 21043					
14. FATHER'S NAME FIRST George			MIDDLE LAST Laricos			15. MOTHER'S MAIDEN NAME FIRST Stella			MIDDLE LAST Pavleros								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No			17. INFORMANT Barbara Laricos, 6437 Lehnert St. 21207			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Pancreatic CA																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I this hospital) attended the deceased from 2 19 87 to 6 19 87, that (I we) last saw the deceased alive on 6/15/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did not view the body after death.																	
22b. SIGNATURE Alan Shorofsky			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 1717 Green Oak 21207			22f. DATE SIGNED 6/12/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE June 13 '87			23c. NAME OF CEMETERY OR CREMATORIAL Westview Memorial Park			23d. LOCATION CITY OR TOWN Catonsville Balto Maryland								
24. FUNERAL DIRECTOR HARRY H WITZKE & FAMILY FUNERAL HOME, INC.			4112 OLD COLUMBIA PIKE ELLIOTT CITY MD 21043			25a. DATE REC'D. BY REGISTRAR JUN 16 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall								
BP																	
DHMH - 16 60M 7/84 (VRA 15, 4)																	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7540
6-13 1987
M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MILDRED	MIDDLE	A.	LAST	LASKO	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	JUN	DAY	13	YEAR	1987	HOUR	
<i>MILDRED</i>				<i>A.</i>	<i>LASKO</i>				<input checked="" type="checkbox"/>	<input type="checkbox"/>	MONTH	DAY	YEAR					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County</i>	MD.											
FEMALE	WHITE	MARCH 4, 1912	75 YRS.	U.S.A.														
10. CITY OR TOWN OF DEATH <i>COLUMBIA</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6200 F. FORELAND GARTH</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BOOKKEEPER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>REESE BUICK</i>										
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>HOWARD</i>		13c. CITY OR TOWN <i>COLUMBIA</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>6200 F. FORELAND GARTH 21045</i>										
14. FATHER'S NAME FIRST <i>LOUIS</i>		MIDDLE <i>HENRY</i>		LAST <i>HOYER</i>		15. MOTHER'S MAIDEN NAME FIRST <i>MAMIE</i>		MIDDLE		LAST <i>PULSCH</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS <i>3404 ROLLING COURT CHEVY CHASE, MD. 20815</i>		17. INFORMANT <i>WARREN LASKO</i>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Candid-pulmonary arrest</i> DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-sclerotic cardio-vascular disease</i> DOUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>Thomas F. Herbert</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED <i>6-13-87</i>												
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <i>Ellicott City, MD 21043</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>6/16/87</i>		23c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN		23d. LOCATION CITY OR TOWN <i>ROCKVILLE</i>		COUNTY		STATE <i>MARYLAND</i>								
24. FUNERAL DIRECTOR <i>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 17 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Kendall</i>														
5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045																		

of the last 1000 ft.
a small
pond worth

Take another
and another

and another

and another

and another

and another

and another

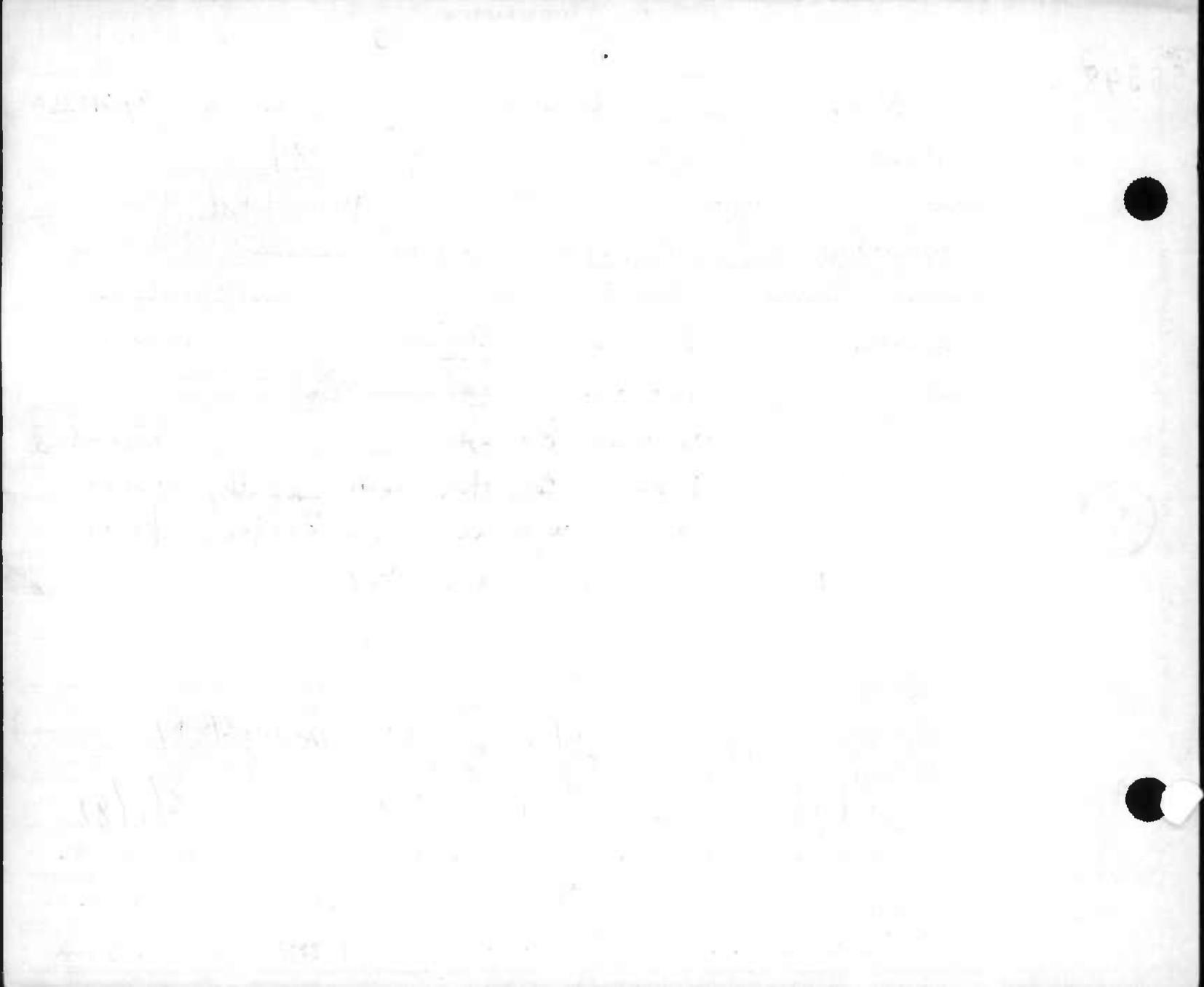
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tomb's permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE • CERTIFICATE OF DEATH															
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Max			LEON	LEVINE		10	20	99	6-5-87			21:25P					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White		MONTH	DAY	YEAR	87	YRS.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH									
Russia			USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard County									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Columbia			Howard County General Hospital										Contractor				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY			
Maryland			Howard		Columbia						10850 Green Mountain Circle			Building			
14. FATHER'S NAME			MIDDLE		15. MOTHER'S MAIDEN NAME												
(Unknown)					(Unknown)									(Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			113-28-8617		Norman Levine			9502 Sylvan Dell			Columbia, Maryland 21045			minutes			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			ischaemic congestive cardiomyopathy			years								
			(b) DUE TO, OR AS A CONSEQUENCE OF														
			(c) acute myocardial infarction			5/26/87											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
Reverberation diabetes																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on			5/26 1987			19 87 to present 6/5/87			19 87, the (I/we) last and that in (my) our opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Stephen A. Valenti, M. D.			22e. ADDRESS			11085 Little Patuxent Pkwy, Columbia, Md. 21044								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION									
Burial			6/7/1987		Riverside Cemetery			Rochelle Park, Bergen, N.J.									
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
									JUN 10 1987			Julia Davidson, Registrar					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be retained for use as the burial-transit permit. Then place it in more carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to removal, or removal, with the State Dept. of Health and Mental Hygiene prior to removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, fill in medical examiner's name in Item 18.

MEDICAL CERTIFICATION

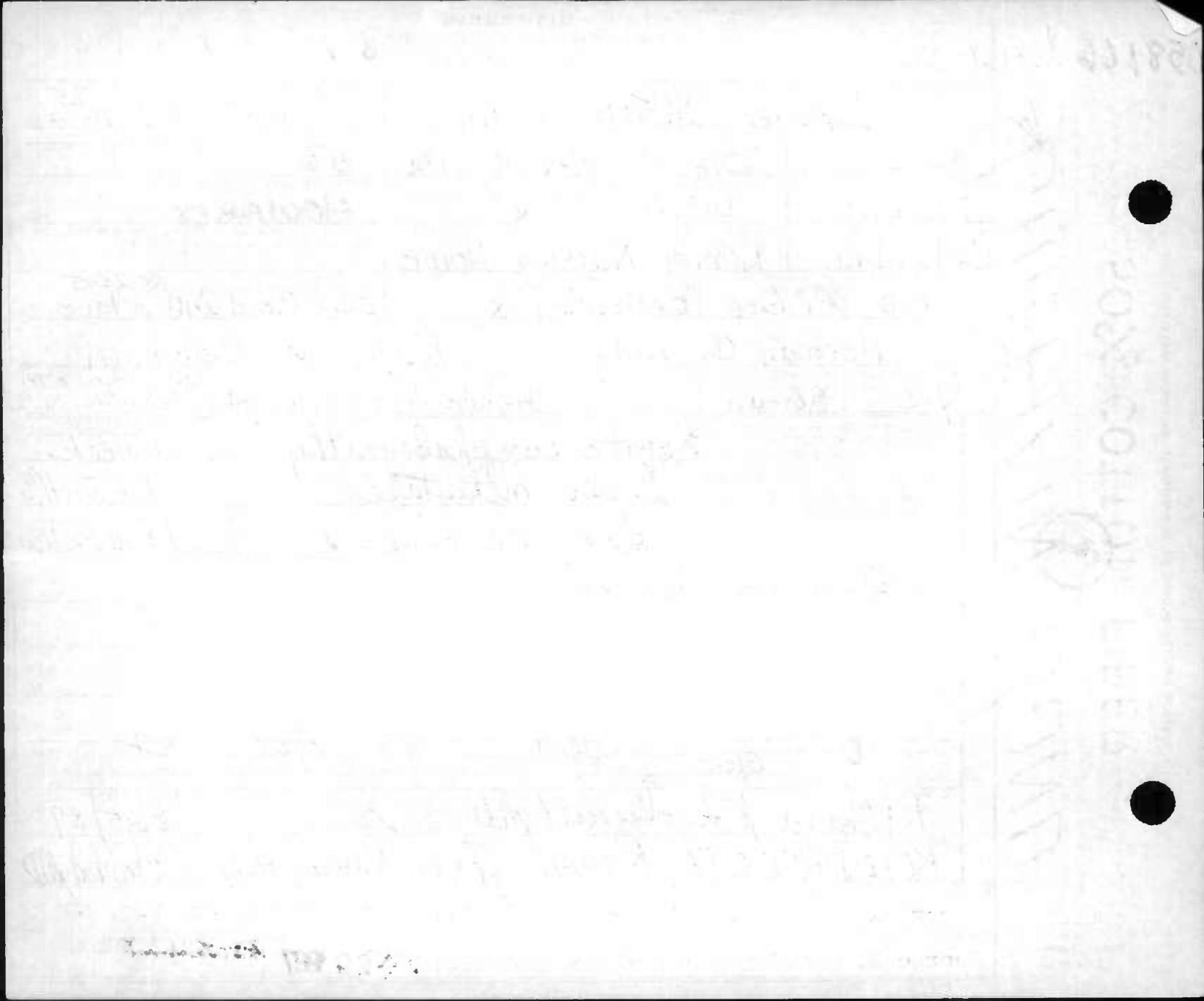
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17542

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Louie Clifton Lilly</i>						<i>6-25-87</i>				<i>10 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		16. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		2b. HOUR	
<i>MALE</i>		<i>BLACK</i>		<i>Nov. 10, 1930</i>		<i>56</i>		MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>TEXAS</i>		<i>U.S.A.</i>				<i>HOWARD</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Columbia</i>		<i>Lorien Nursing Home</i>									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20305	
<i>MD</i>		<i>Pr. Geo. Bells</i>		<i>Bellsville</i>				<i>5400 Cordwall Place</i>			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
<i>Herman C. Lilly</i>						<i>Ruth M. Coleman</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>Yes</i>		<i>Korean</i>		<i>Michelle Jennings (daughter) Zebulon, N.C.</i>		<i>RT 3, Box 874</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						<i>Hepatic encephalopathy</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>liver metastases</i>						1 week					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>colon carcinoma</i>						18 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>obstructive jaundice</i>						18 months					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> , 19 <i>87</i> , to <i>6/25</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>6/25</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SKINNATRE		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <i>6/25/87</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS <i>KOLODRUBETZ, RICHARD Lorien Nursing Home Columbia, MD</i>									
23a. BURIAL, CREMATION, REMOVAL TYPE		23b. DATE <i>Burial 6-30-87</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Md. Nat'l Mem. Park Laurel, Pr. Geo. MD</i>		23d. LOCATION					
24 FUNERAL DIRECTOR NAME		ADDRESS		25e. DATE REC'D. BY REGISTRAR <i>11/29/87</i>		25f. MEDICAL SIGNATURE					
<i>George R. Snowden</i>		<i>Rockville, MD 20850</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

item 7b, 23b G 628
FOR 6-12-87 by F.H. GBJ.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 17543

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR			
Lily June Marangeria						June 7 1987				9:30 P M			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)							
Female		Caucasian	MONTH	DAY	YEAR	95	IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Canada		USA				Howard MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Lorien Nursing			HOME MAKER					DOMESTIC			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			14. FATHER'S NAME		
MD		HOWARD	COLUMBIA					10381 BACON CIR. 21044			FIRST ALAN MIDDLE ADAMSON LAST TURRIFF		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		124-09-2254			Ms. Dow Simpson		10381 BACON CIR. Columbia, MD. 21044						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease		DUE TO, OR AS A CONSEQUENCE OF (b) Age											
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Gangrene RT. foot													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (the hospital) attended the deceased from approx. 19.74 to 6/07.19.87, that (I) (we) lost saw the deceased alive on 5-21 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE B.R. Minchen, M.D.		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 6/08/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22e. ADDRESS					22e. ADDRESS			
B.R. MINCHEN, M.D.					ELICOTT CITY, MD. 21043								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL WESTVIEW Mem. Pk.			23d. LOCATION CITY OR TOWN CATSBURG BAND.		STATE MD.				
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS Box 268 ELICOTT CITY, MD 21043		25a. DATE REC'D. BY REGISTRAR JUN 9 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall						

ABNORMAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remember to file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event the medical examiner must be notified at once.

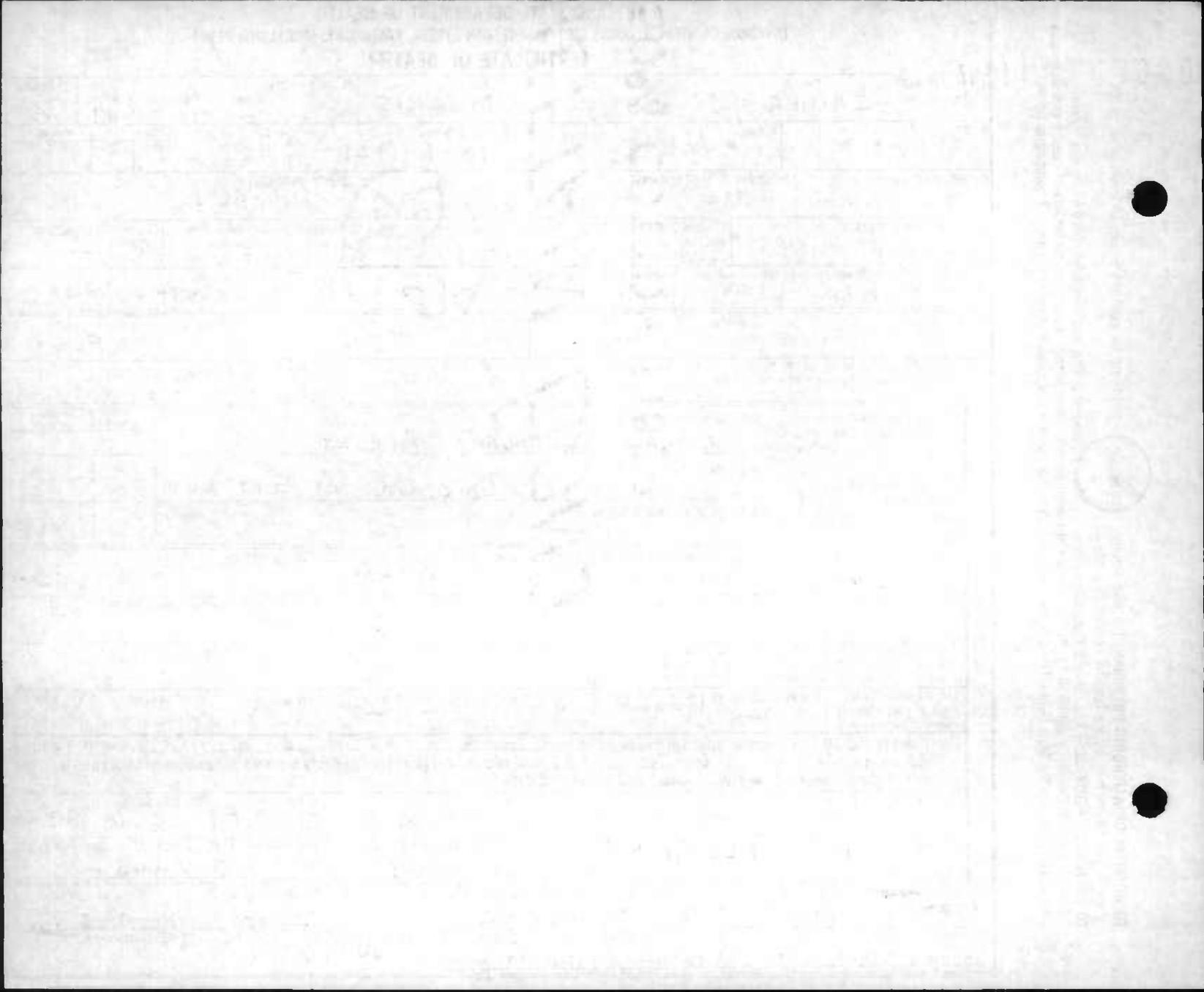
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR			
<i>Florence</i>					<i>Mascott</i>	<i>6 21 87</i>					<i>9 20</i>				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>			<i>White</i>		<i>08 26 98</i>			<i>88</i>			MONTH	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>CONN</i>			<i>U.S.</i>					<i>Howard</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
<i>Columbia</i>			<i>Lorien Nursing Home</i>									<i>Housewife</i>			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			Columbia, Md.	
<i>MD</i>			<i>Howard</i>		<i>Columbia</i>			YES <input type="checkbox"/> NO <input type="checkbox"/>			<i>6334 Cedar Lane</i>			<i>21044</i>	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
<i>Elmer</i>				<i>Ware</i>	<i>Violet</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>			<i>158-07-3338</i>			<i>Charles Mascott</i>			<i>10799 Hickory Ridge Road</i>			<i>1 month</i>			
<i>Columbia, Md. 21044</i>															
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			(b) <i>Chronic renal failure</i>												
			(c) <i>Year</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 21 1987</i> to <i>June 21 1987</i> , that (I) (we) last saw the deceased alive on <i>June 21 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															
22b. SIGNATURE <i>Charles E Taylor</i>			22c. DEGREE <i>my</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>6-22-87</i>						
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles E Taylor</i>			22g. ADDRESS <i>2 Knoll North Drive Columbia MD 21045</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/25/87</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>			23d. LOCATION CITY OR TOWN <i>E. Hanover</i>			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <i>HARRY H. WITZKE</i>			ADDRESS <i>4112 Columbia Rd., ELlicott City</i>			25a. DATE REC'D. BY REGISTRAR M.D. REC'D. BY CLERK <i>JUN 25 1987 Julia DeLoach</i>									

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many events within 24 hours after death.

1. DECEASED-NAME (Type or print)				First CATHERINE	Middle BELLE	Last MORRIS	2a. DATE OF DEATH Month 6	Day 10	Year 1987	2b. HOUR 7:30AM			
3. SEX FEMALE.		4. RACE WHITE		5. DATE OF BIRTH 10-6-1921		6. AGE (in years lost birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS 6			IF UNDER 24 HRS. HOURS 7		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HOWARD							
10. CITY OR TOWN OF DEATH ELLIOTT CITY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4080, CHOCTAW DRIVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY -							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE M.D.		13b. COUNTY HOWARD		13c. CITY OR TOWN ELLIOTT CITY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4080, CHOCTAW DRIVE					
14. FATHER'S NAME First FLEX		15. MOTHER'S MAIDEN NAME First IVA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-01-2270		17. INFORMANT David Morris		Address 4080 CHOCTAW DRIVE ELLIOTT CITY MD 21043					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO - PULMONARY ARREST													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) SQUAMOUS CELL CARCINOMA OF LEFT LUNG													
DUE TO, OR AS A CONSEQUENCE OF (c) -													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. — 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) -									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) -		21f. LOCATION Street or R.F.D. No. -		City or Town -		County -		State -			
22a. I certify that (I) (this hospital) attended the deceased from 6-4- , 19 87 , to 6-9- , 19 87 , that (I) (we) last saw the deceased alive on 6-4- , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) () (did) () view the body after death.													
22b. SIGNATURE N.B. Vellanki		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 6-10-87					
22d. PHYSICIAN'S NAME (Type) N.B. VELLANKI		22e. ADDRESS 9055, CHEVROLET DRIVE #101 ELLIOTT CITY MD 21043											
23a. BURIAL / CREMATION, Specify		23b. DATE June 13, 1987		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral		23d. LOCATION (City or Town) Baltimore		(County) Maryland		(State)			
24. FUNERAL DIRECTOR Harry H Witzke 4112 Old Columbia Pike Ellicott		ADDRESS —		City —		25a. REC'D BY REGISTRAR JUN 12 1987		25b. REGISTRAR'S SIGNATURE John R. Rands		DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FilmG631 item 13a,b,c,d,e,
FOR 9/17/87 rja per F.H.
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

17546

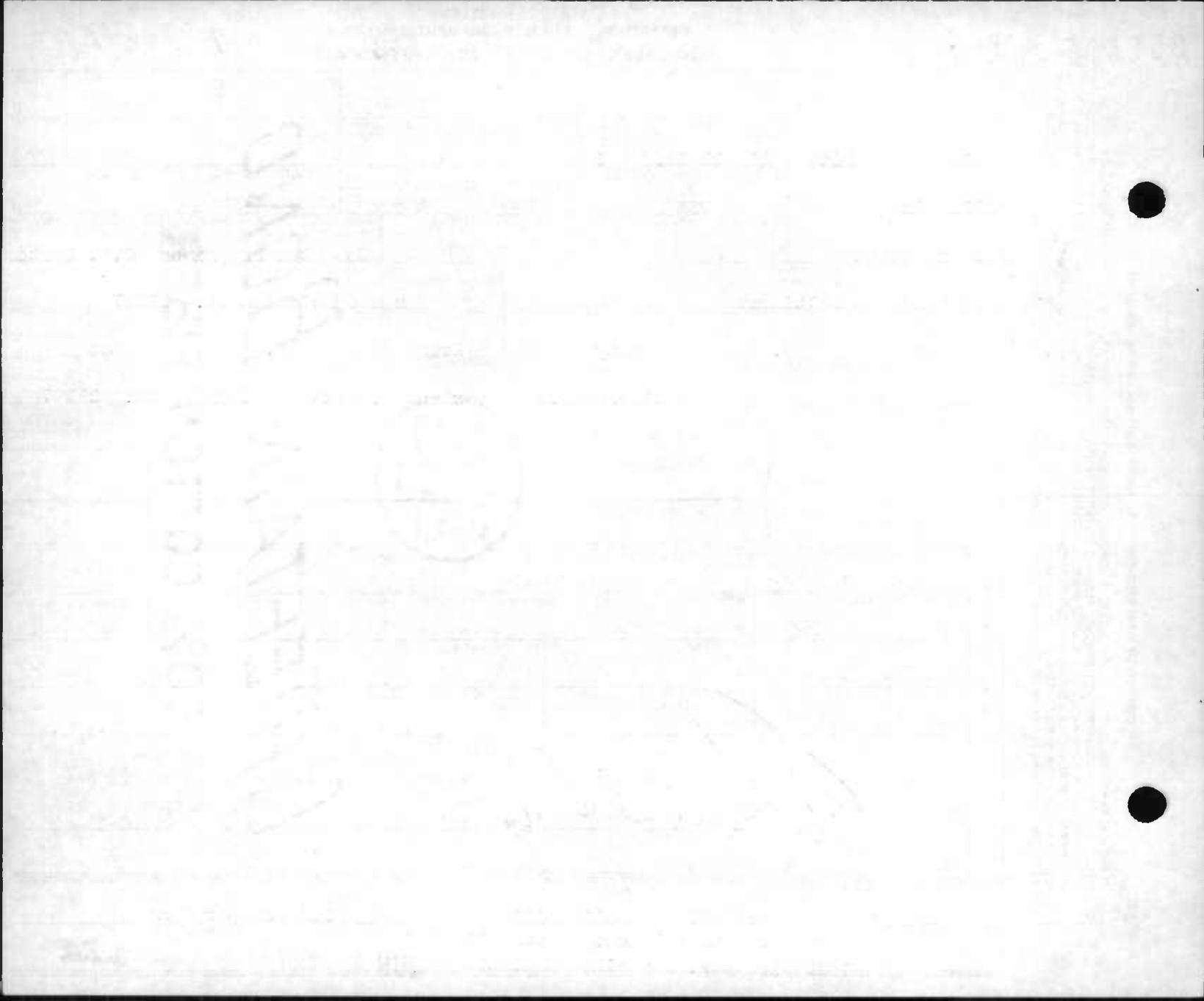
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
STANLEY					ORTYL	JUNE	20	1987	8:30 A.M.								
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
MALE			W	MONTH	DAY	YEAR	85 YRS.										
6. MONTH JUN			7. DAY 20			8. YEAR 1987											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Columbia			Howard County General Hospital						HOWARD								
10. CITY OR TOWN OF DEATH												11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Columbia												Howard County General Hospital		58 Barbuda St. 08757			
13a. STATE AD N.J.		13b. COUNTY Howard		13c. CITY OR TOWN Berkeley Township		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Cedartone Ln 21044									
14. FATHER'S NAME FIRST		Nydia		LAST		15. MOTHER'S MAIDEN NAME FIRST		Natalia		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. -----		16c. ADDRESS 137-03-8495		17. INFORMANT Richard Ortyl		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS Ellicott, MD. 3618 Font Hill Rd.							
								upper airway obstruction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 96 hrs							
								DUE TO, OR AS A CONSEQUENCE OF (b)		Carcinoma of the larynx							
								DUE TO, OR AS A CONSEQUENCE OF (c)		1 year							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Scot Maurer		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAURER				22e. ADDRESS 10772 HICKORY RIDGE, COLUMBIA, MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-25-87		23c. NAME OF CEMETERY OR CREMATORIAL ST. CATHERINES				23d. LOCATION CITY OR TOWN Sea Girt, Monmouth NJ,									
24. FUNERAL DIRECTOR NAME John Clark		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 1987				25b. REGISTRAR'S SIGNATURE John Clark									
BP																	
DHMH - 16 60M 7/84 (VRA 15, 4)																	

1980-1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3, RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR MONTH DAY YEAR	2d HOUR
GUY ALLEN PARTY						<input checked="" type="checkbox"/>			6-12-87 ¹⁹	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE Pronounced Dead	MONTH	DAY	YEAR	2d HOUR	
Male	White	11 11 1950	36 yrs.			6-12-87 ¹⁹				5:40P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County					
Illinois		USA									
10. CITY OR TOWN OF DEATH Howard County		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Md. Rt. 108, ½ mile E. of Rt. 32					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Programmer				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 6 McLendon Ct. 21207					
14. FATHER'S NAME John		MIDDLE O.		LAST Party		15. MOTHER'S MAIDEN NAME Irene R. Lee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-58-2132		17. INFORMANT Darlene E. Party 6 McLendon Ct. 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>arteriosclerotic cardiovascular disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:35PM 6-12-87 ¹⁹		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) driver of auto involved in collision with truck by vehicle							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.		21f. STREET CITY OR TOWN Md. Rt. 108, ½ mile E. of Howard Co., Md.							
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE <u>John E. Smialek, M.D.</u> MEDICAL EXAMINER DATE SIGNED 6-13-87											
EXAMINER'S NAME (TYPE OR PRINT)		John E. Smialek, M.D.					ADDRESS 111 Penn Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6-17-87		23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill			23d. LOCATION CITY OR TOWN Baltimore Maryland		COUNTY STATE		
24. FUNERAL DIRECTOR NAME		Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222					25a. DATE REC'D. BY REGISTRAR JUN 15 1987		25b. REGISTRAR'S SIGNATURE <u>Lisa Deacon-Readell</u>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

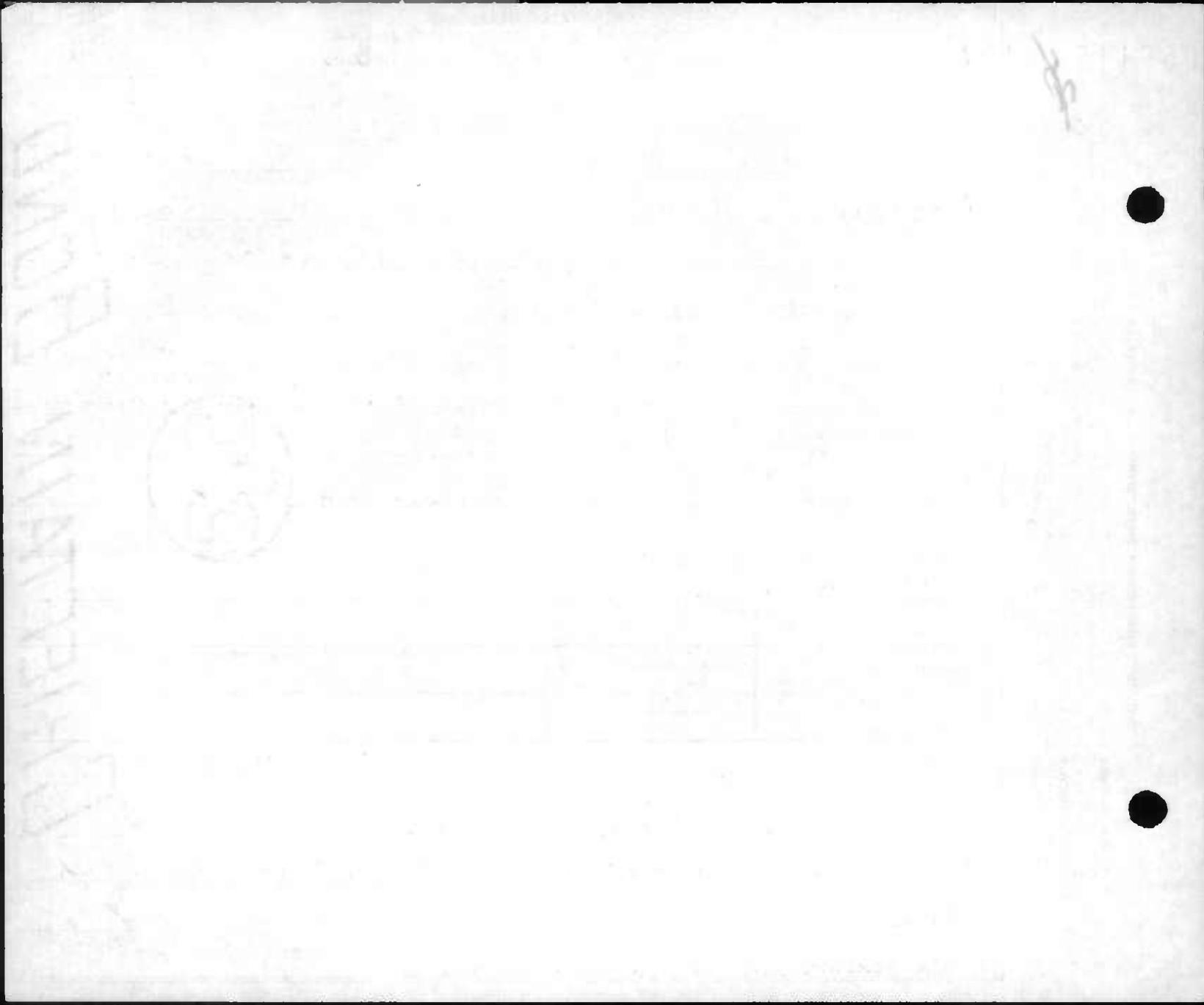
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17548

REG. NO.

FOR STATE REGISTRAR		LAST										2d. DATE KNOWN OF ESTI. DEATH MATED		MONTH DAY YEAR		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		IF UNDER 1 YR.		IF UNDER 24 HRS.									
Herman M. Pfeiffer																	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
MALE		White		02 17 01		86 yrs.						06.05 1987				1648 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Howard County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Columbia		Howard County Gen. Hosp.		Carpentry		Self-employed											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
MD.		Howard		Ellicott City		YES <input type="checkbox"/>		6220 Waterloo Road									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME									
John						Pfeiffer		Mary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS									
no		-		216-10-6908		Grace Pfeiffer		6220 Waterloo Rd									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)		Due to, or as a consequence of															
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> .		(b) Arteriosclerotic Cardiovascular Disease															
		DUE TO, OR AS A CONSEQUENCE OF															
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		Diabetes mellitus															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?	
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion									
death resulted from: Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Thomas F. Herbert		M.D.		Deputy		MEDICAL EXAMINER								DATE SIGNED 6-5-87	
EXAMINER'S NAME (TYPE OR PRINT)		Thomas F. Herbert M.D.		ADDRESS		Ellicott City MD 21043											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE							
Burial		8 JUNE 87		TRINITY EPISCOPAL CEM.		Ellicott City		Md		MD							
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
SLACK Funeral Home Ellicott City MD 21043								JUN 9 1987		Julia Deardon-Randall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 4 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8717549		
1 - STATE REGISTRAR			FIRST PETER J. POINTAK MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 100 A.M.		
1. DECEASED NAME (TYPE OR PRINT)									June 24, 1987					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH October 24, 1912			6. AGE (IN YEARS LAST BIRTHDAY) 74			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.					
10. CITY OR TOWN OF DEATH Ellicott City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9742 Michaels Way			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired V.P., Bakers Union			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Howars			13c. CITY OR TOWN Ellicott City			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 9742 Michaels Way 21043		
14. FATHER'S NAME Casimir Pincoski						15. MOTHER'S MAIDEN NAME Anna								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 204 09 3711			17. INFORMANT Mrs Patricia Saleh 9742 Michaels Way			ADDRESS 21043					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amotrophic Lateral Sclerosis, spinal progressive</u>												24 hrs INTERVAL ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Normal Pressure Hydrocephalus</u>												24 yrs		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Progressive Spinal Amyotrophic Lateral Sclerosis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>3-5 yrs</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <u>Glen E Johnson</u>			22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>6/24/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GLEN E JOHNSON</u>			22e. ADDRESS <u>SUITE 202 PINE HEIGHTS MED CTR</u> <u>1001 PINE HEIGHTS AVE BLDG. 21229</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 27'87			23c. NAME OF CEMETERY OR CREMATORIAL St Johns			23d. LOCATION CITY OR TOWN Ellicott City			23e. COUNTY Howard		
24. FUNERAL DIRECTOR <u>HARRY H WITZKE & FAMILY</u> <u>FUNERAL HOME, INC.</u>			24b. ADDRESS <u>4112 OLD COLUMBIA PIKE</u> <u>ELLIOTT CITY MD 21043</u>			25a. DATE REC'D. BY REGISTRAR <u>JUN 25 1987</u>			25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Lindell</u>					

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at 0100 HRS THIS MORNING. THE DATA IS AS FOLLOWS:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8717550		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
FRANCES					ROTONDO	6/20/87						9:55 AM		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		2b. HOUR		
F			W	MONTH 12 DAY 09 YEAR 93			93 YRS.			MONTHS	DAYS	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Sicily			USA						Howard Co.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
COLUMBIA			LORIEN NURSING HOME			Homemaker								
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland			Baltimore	Catonsville				1022 Marksworth Road, 21228						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Anthony					Civello				Marie	Angela	UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			213-74-0422			Herman Ingram, 2810 Leaf Shade Drive						8 days		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Paralytic Ileus</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Metatarsis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						<input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> , 19 <u>85</u> , to <u>6-21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5-30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
<u>Kushma P. Kumar</u>									<u>6-21-87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Dr. Kumar			Hickory Ridge Rd 10802 Hickory Ridge Rd.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____							
Burial			6/24/87	Most Holy Redeemer			Baltimore			Maryland				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc., 4107 Wilkens Ave.			21229			JUN 22 1987			<i>[Signature]</i>					

Wade

Mark

John

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Papers 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR ¹			
<i>EVA</i>				<i>VIRGINIA</i>	<i>ROWE</i>		<i>6-16-87</i>				<i>4:48 PM</i>			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Negro		Feb. 2, 1898			89		YRS	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.							Howard County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Columbia		Howard County General Hospital		homemaker		own home								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
Maryland		Howard		Baltimore				6617 Birchway Drive 21227						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST					
		Newman		Brown			Jane		Hickman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a), (1b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no		076-28-8556		Florence Reid		CARNO PULMONARY FAILURE		1143 E. 213th Street Bronx, New York 10469						
18c. DUE TO, OR AS A CONSEQUENCE OF (b)		18d. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION <i>5-25-87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>INTESTINAL OBSTRUCTION</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (the hospital) attended the deceased from <i>5-8-87</i> to <i>6-16-87</i> , that (I) (we) last saw the deceased alive on <i>6-16-87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Keith Falcao</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/16/87</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KEITH FALCAO</i>		22e. ADDRESS <i>3350 Wilkins Ave. Bldg. 14.</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>June 13, 1987</i>		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Cemetery		23d. LOCATION CITY OR TOWN <i>Lincoln, Virginia</i>		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME Loudoun Funeral Chapel		ADDRESS P.O. Box 1316		25a. DATE REC'D. BY REGISTRAR <i>JUN 22 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Randall</i>								
DHMH - 16 60M 7/84 (VRA 15, 4)														

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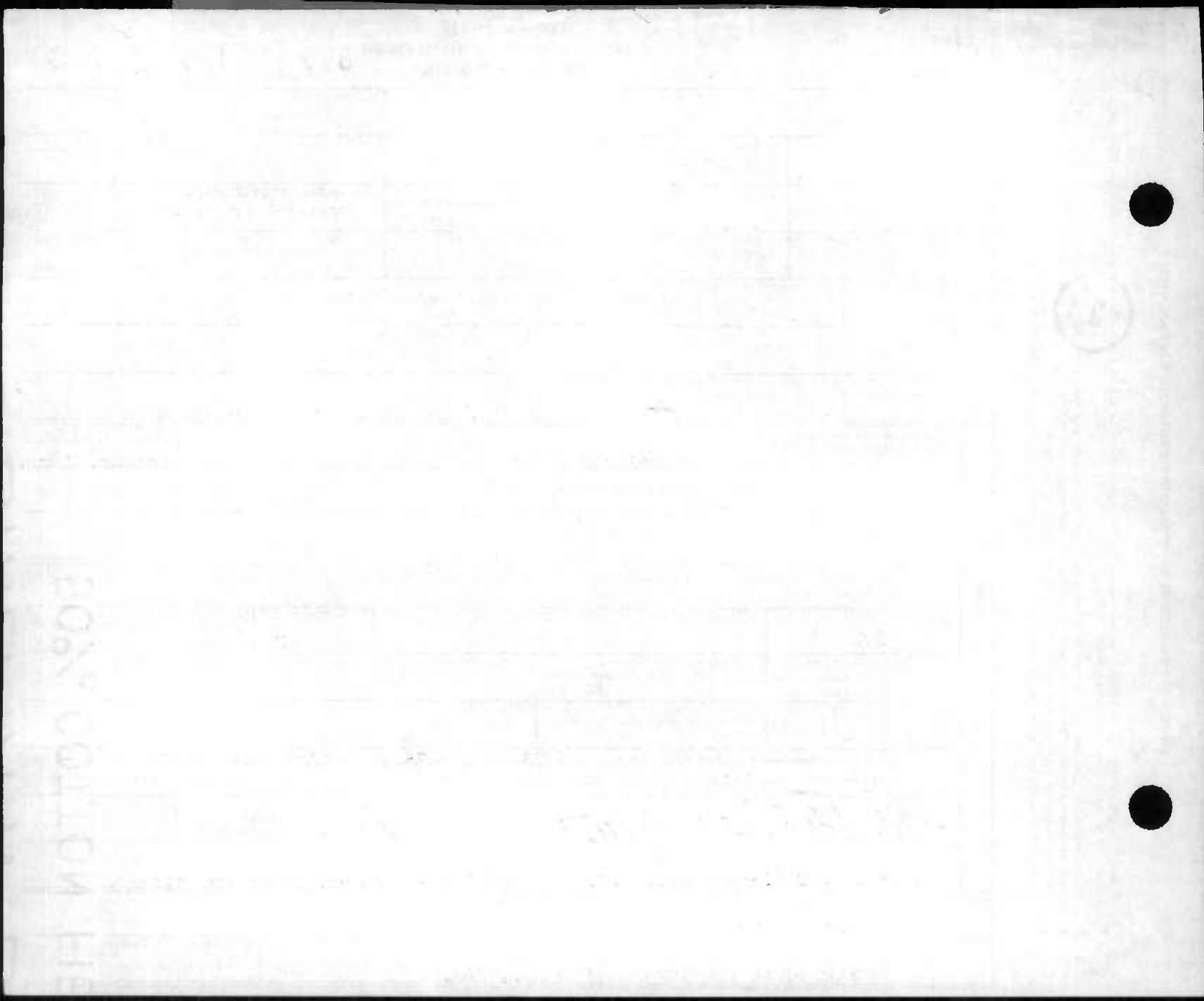
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified alone.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified alone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8717552														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR										
WILMER M. SANNER												6	1	87		M										
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS											
Male			White			MONTH DAY YEAR			85			MONTHS DAYS			HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH																	
Maryland			U.S.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Howard County																	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
Ellicott			3109 Edgewood Rd.			Broker			Printing																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
												Md.			Howard			Ellicott City			<input checked="" type="checkbox"/> NO <input type="checkbox"/>			3109 Edgewood Rd. 21043		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST											
George			Roberts			Sanners			Laura			I.			Mackey											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
NO			213-03-9947 →			Ms. Avie E. Sanner - Same as #13						approx. 1 yr														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:																										
IMMEDIATE CAUSE (a) <u>Generalized ASCVD</u>																										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.												(b)														
{ DUE TO, OR AS A CONSEQUENCE OF (c)																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE											
22d. I certify that (I) (this hospital) attended the deceased from 5/23, 1975, to 5/29, 1987, that (I) (we) last saw the deceased alive on 5/29, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22e. DATE SIGNED														
22b. SIGNATURE <u>Wilmer K. Gallager, Jr., M.D.</u>												DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN											
Removal			6-1-87									3455 Wilkens Ave. Balto MD 21229														
24. FUNERAL DIRECTOR NAME			ADDRESS			25d. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
State Anatomy Board			Balto., Md.			JUN 09 1987						<u>Julia Dawson-Readee</u>														

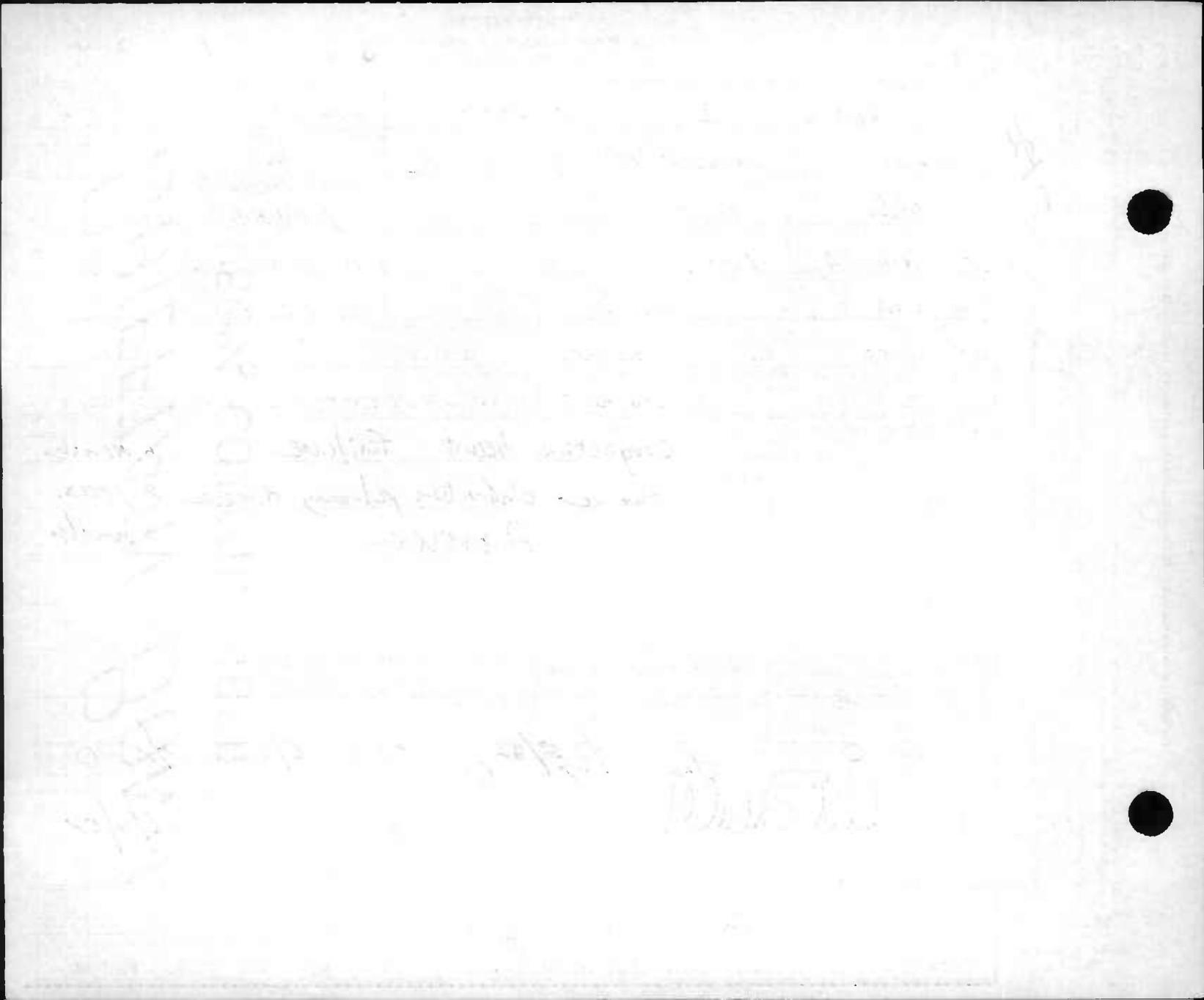


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in the funeral director's page 3 book. If item 18 shows any injury, or other traumatic event, the medical examiner should be notified. This certificate should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2, if used, should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8717553											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR
<i>Gabriel E. SERVARY</i>						<i>6/12/87</i>					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2d. HOUR	
<i>Male</i>		<i>Caucasian</i>		MONTH	DAY	YEAR	<i>94 yrs</i>			<i>3A M</i>	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
<i>Md.</i>		<i>USA</i>					<i>Howard County MD.</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Columbia</i>		<i>Lorien Nursing Home</i>					<i>Head Maintenance Man Drug Co.</i>				
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>617 Orpington Road 21229</i>	
FATHER'S NAME FIRST <i>Henry</i>		MIDDLE <i>A.</i>		LAST <i>Servary</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Amelia</i>			MIDDLE <i>Staubitz</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-07-0561</i>		17. INFORMANT			ADDRESS			21227	
							<i>William H. Servary 6831 Montgomery Rd.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>chronic obstructive pulmonary disease</i> 2 years. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Anorexia</i> 3 months.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that <input type="checkbox"/> (I) this hospital attended the deceased from <i>4/30/82</i> 19 <i>02</i> to <i>6/1</i> 19 <i>87</i> , that <input type="checkbox"/> (we) last saw the deceased <i>5/22/82</i> 19 <i>87</i> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) <input type="checkbox"/> (we) last saw the body after death.		22b. SIGNATURE <i>John Sheehan</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>6/12/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Sheehan</i>		22e. ADDRESS <i>3459 St. Johns Lane at Chevrolet Drive</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/5/87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Baltimore</i>			COUNTY	STATE <i>maryland</i>
24. FUNERAL DIRECTOR NAME <i>Hubbard Funeral Home, Inc.</i>		ADDRESS <i>21229 4107 Wilkens Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 3 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)											

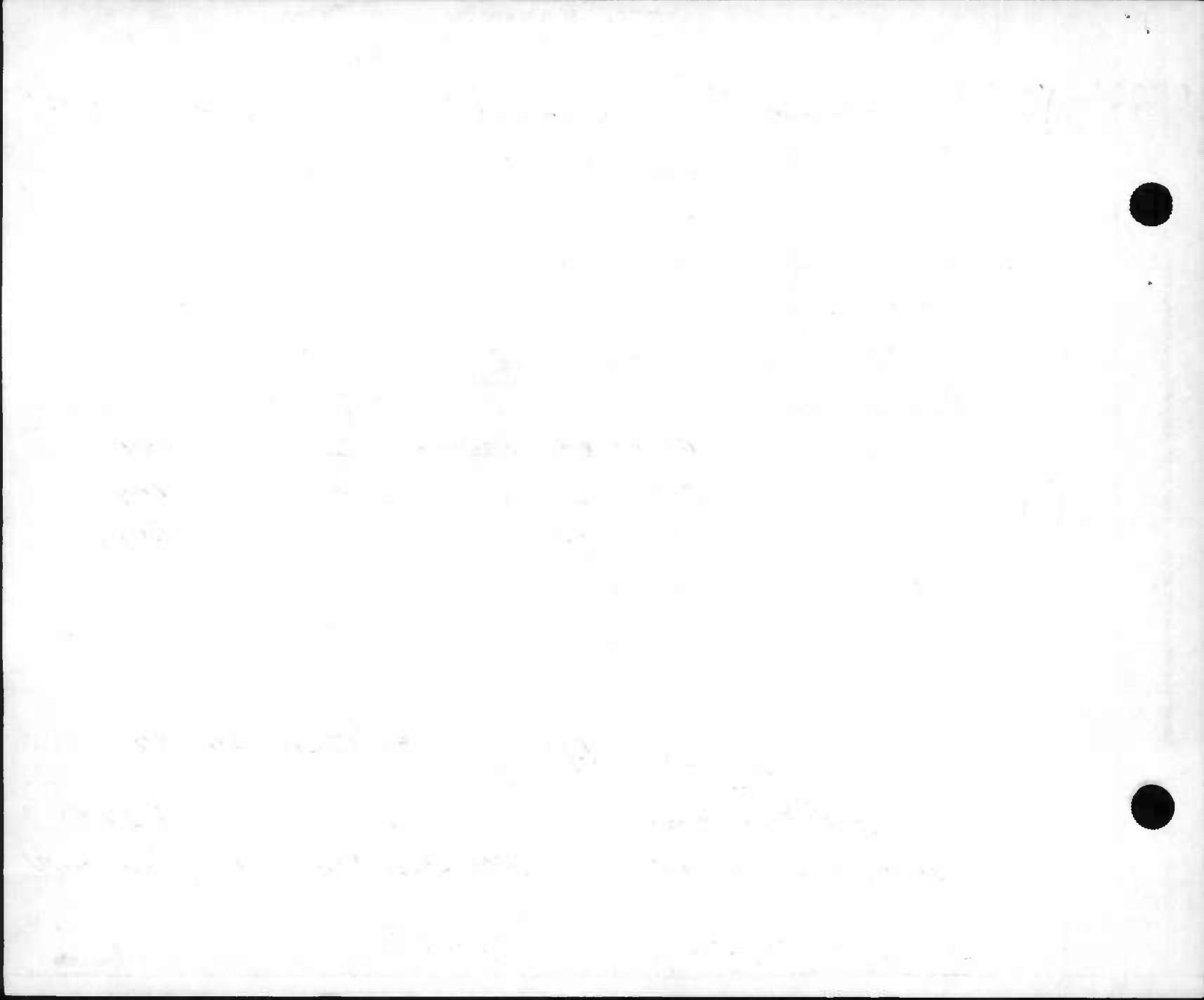


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked Item 18 shows any injury or other trauma, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 17654											
1 - FOR STATE REGISTRAR		F. DECEASED NAME (TYPE OR PRINT)			FIRST LORRAINE MIDDLE L.		LAST SCHULER		2a DATE OF DEATH MONTH 6 DAY 27 YEAR 87 2b. HOUR 6 27 87 5:56 P.M.		
3. SEX FEMALE		4 RACE WHITE			5. DATE OF BIRTH MONTH DECEMBER DAY 9, 1934 YEAR 1934		6. AGE IN YEARS (LAST BIRTHDAY) 52			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW HAMPSHIRE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.				
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN SAVAGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8287 WOODWARD STREET 20763			
14. FATHER'S NAME FIRST ALPHONSE MIDDLE P. LAST OUELLETTE					15. MOTHER'S MAIDEN NAME FIRST LOUISE MIDDLE A. LAST ADAMS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 002-24-9199			17. INFORMANT ARTHUR SCHULER		ADDRESS SAME AS # 13				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> <u>Days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u> <u>Days</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> 19, 19 <u>87</u> , to <u>June 27, 1987</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. Schuler</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>6-27-87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Vernon J. Schuler, MD</u>		22e. ADDRESS <u>11055 Little Piedmont Pkwy, Columbia, MD</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/1/87		23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE		23d. LOCATION CITY OR TOWN DORSEY		COUNTY		STATE MARYLAND	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE ADD'L 5555 TWIN KNOLLS ROAD, COLUMBIA, MD.		25a. DATE REC'D. BY REGISTRAR JUN 30 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Randall</u>							
DHMH - 16 60M 7/84 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 7 1 7 5 5 5											REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			LAST			2a. DATE OF DEATH			2b. HOUR		
Mildred F. Scott									6 24 87			12:04 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 5 11 1905			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD.					
10. CITY OR TOWN OF DEATH COLUMBIA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT					
13a. STATE MD			13b. COUNTY HOWARD			13c. CITY OR TOWN COLUMBIA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6336 CEDAR LANE 21044		
14. FATHER'S NAME John			MIDDLE NAME WALTER MEYER			15. MOTHER'S MAIDEN NAME Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-26-8823			17. INFORMANT PAT LEARY 848 DEERWOOD CT 21401								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral pulmonary arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>vertebrae body broken</u>												30 mins		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u>												yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>COPD, w. of recurrent vertebro body break, cardiopathy.</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>82</u> , to <u>6/24</u> , 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>6/24</u> , 19 <u>82</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> did (did not) view the body after death.														
22b. SIGNATURE <u>Charles E. Shedd</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>6/24/87</u>					
22e. ADDRESS														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Shedd MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 6-26-87			23c. NAME OF CEMETERY OR CREMATORIAL SECRETARIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
24. FUNERAL DIRECTOR NAME CREMATION SOC. OF MD.			ADDRESS 86070			25e. DATE THIS CERTIFICATE WAS SIGNED JUN 26 1987								

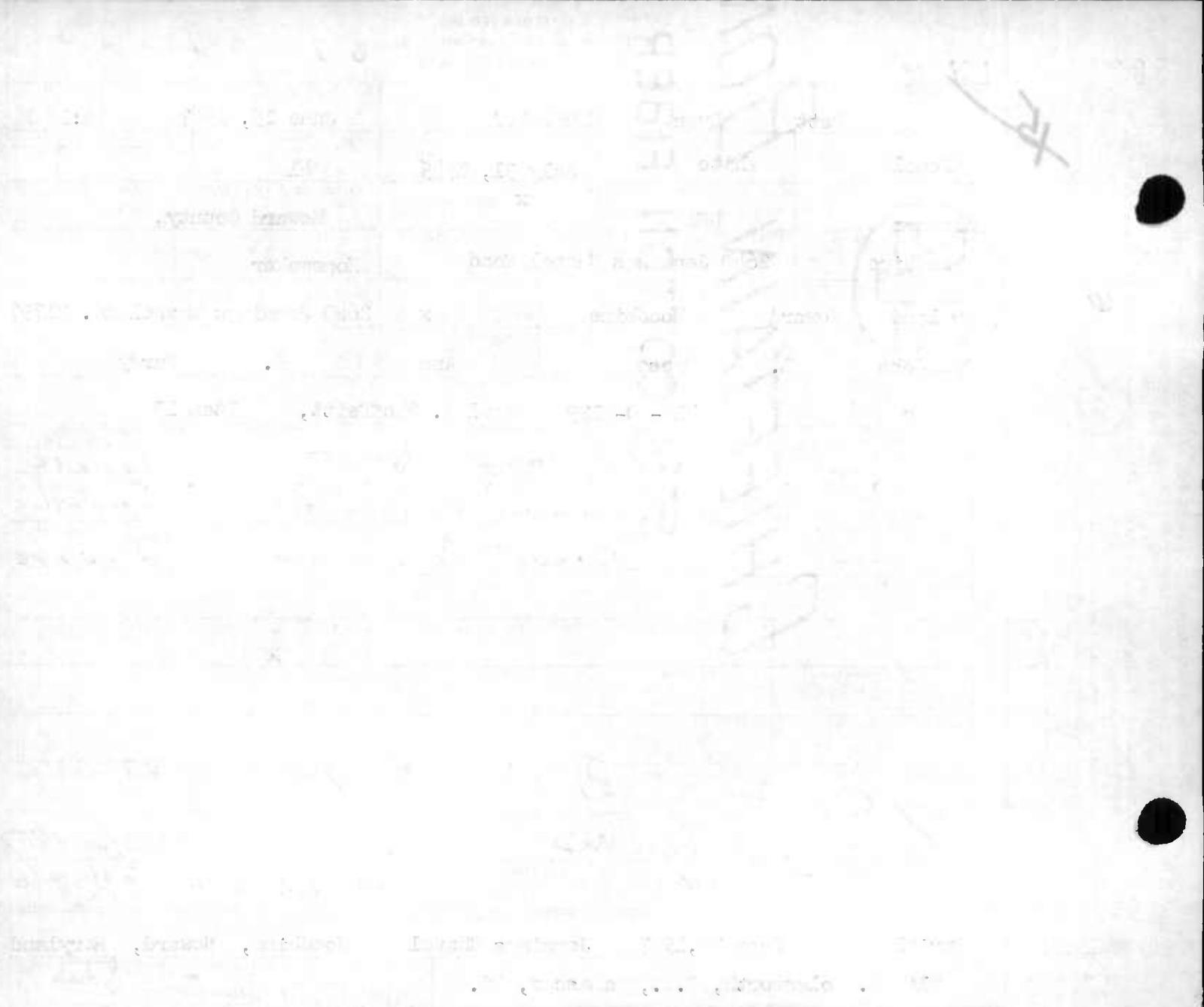


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 7 17556				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
<i>Betty Lynn SHOFFEITT</i>								June 25, 1987						4:18 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR July 31, 1945			6. AGE (IN YEARS LAST BIRTHDAY) 41			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Howard County, MD.							
10. CITY OR TOWN OF DEATH Woodbine			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2640 Jennings Chapel Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Howard			13c. CITY OR TOWN Woodbine			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2640 Jennings Chapel Rd. 21797				
14. FATHER'S NAME FIRST John			MIDDLE L.			LAST Reese			15. MOTHER'S MAIDEN NAME FIRST Ann			MIDDLE P.		LAST Purdy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 419-60-5129			17. INFORMANT Paul G. Shoffeitt, Item 13			ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 minute</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Carcinomatous meningitis</i>												5 months				
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Breast Carcinoma</i>												2 years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1986</i> , to <i>June 25, 1987</i> , that (I) (we) last saw the deceased alive on <i>June 25, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Kevin J. Cullen MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/25/87</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kevin J. Cullen</i>			22e. ADDRESS <i>Bld. 1010 12N226 NIH Bethesda MD</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 28, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Jennings Chapel			23d. LOCATION CITY OR TOWN Woodbine, Howard, Maryland							
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.			25a. DATE REC'D. BY REGISTRAR JUN 30 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Laddie</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The
retained by the hospital or attending physician

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

17557

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH S. WALL			2a DATE OF DEATH MONTH 6 287	2b. HOUR 240 PM
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 04/04/11	6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS	7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Holowan	
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIEN NURSING HOME			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED SUPERVISOR
13a STATE MARYLAND	13b COUNTY --	13c. CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 615 NOTTINGHAM ROAD 21229
14. FATHER'S NAME FIRST WILLIAM	MIDDLE STICHEL	LAST	15. MOTHER'S MAIDEN NAME FIRST HELEN	MIDDLE M. LAST STEVENS
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-05-1465	17 INFORMANT WESTON P. BOUSMAN	ADDRESS 9822 LONGVIEW DRIVE ELLIOTT CITY, MD. 21043	18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meter Sulfate Breast Cancer				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____				
DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (he/she) attended the deceased from <u>9/13</u> , 19 <u>87</u> , to <u>6/1</u> , 19 <u>82</u> , that (we) last saw the deceased alive on <u>3/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
22b. SIGNATURE 	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Sheehan M.D.	22e ADDRESS LORIEN NURSING HOME, COLUMBIA, MD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE 6/4/87	23c NAME OF CEMETERY OR CREMATORIAL LORRAINE PARK	23d LOCATION CITY OR TOWN WOODLAWN	STATE MARYLAND
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	25a DATE REC'D. BY REGISTRAR JUN 8 1987		25b. REGISTRAR'S SIGNATURE 	

18

19

058551

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 | 7558

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Dori's J White						6	29	87	5:05 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Female		White		MONTH	DAY	YEAR	54							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Michigan		USA		MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Howard						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Columbia		Howard Co. General Hosp.		RN			Health							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		Baltimore 21096				
Md.		Howard		Columbia				6726 Carlinda Ave.						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Charlse				Duryee		Margret				Laever				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS								
N		383-300197		Donald White		Same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septacemia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours		
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Rheumatoid arthritis												30 years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to June 29, 1987, that (I) (we) last saw the deceased alive on June 29, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Janet Clarkowski</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-29-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janet Clarkowski		22e. ADDRESS 21 Knoll North Drive Columbia Md 21045												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/87		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn		23d. LOCATION CITY OR TOWN Marriottsville Ho. Md.								
24. FUNERAL DIRECTOR HARRY H. WITZKE		4112 Columbia Rd. ADMITTED Ellicott City, Md, 21043		25a. DATE REC'D. BY REGISTRAR JULY 1 1987		25b. REGISTRAR'S SIGNATURE Julia Dawson-Landalee								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trunk permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Re 1900 2000 2100 2200 2300 2400 2500

Re 2600 2700 2800 2900 3000 3100 3200

Re 3300 3400 3500 3600 3700 3800 3900

Re 4000 4100 4200 4300 4400 4500 4600

Re 4700 4800 4900 5000 5100 5200 5300

Re 5400 5500 5600 5700 5800 5900 6000

Re 6200 6300 6400 6500 6600 6700 6800

Re 6900 7000 7100 7200 7300 7400 7500

Re 7600 7700 7800 7900 8000 8100 8200

Re 8300 8400 8500 8600 8700 8800 8900

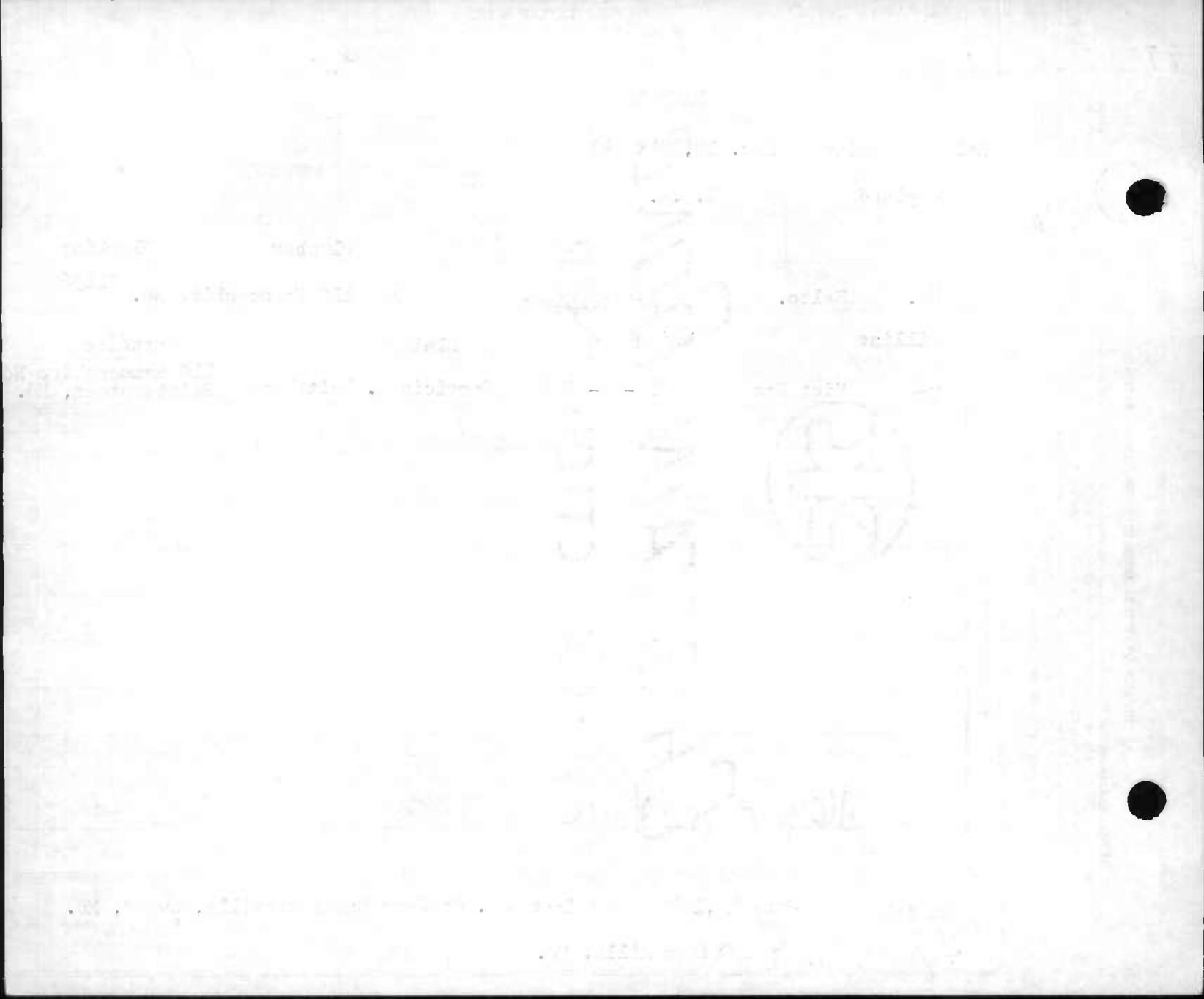
Re 9000 9100 9200 9300 9400 9500 9600

Re 9700 9800 9900 10000 10100 10200 10300

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17559											
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	1b. HOUR				
		WILLIAM LAWRENCE WHITEHEAD										<input checked="" type="checkbox"/>									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d HOUR				
Male		White		Dec. 10, 1943		43		MONTHS		DAYS		HOURS		MIN.		6-15-87		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED		XX NEVER MARRIED				WIDOWED		DIVORCED				9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				<input checked="" type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>				Howard County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Columbia		Howard Co. General Hospital				Plumber				Plumbing											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md.		Balto.		Reisterstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		110 Hammershire Rd.													
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		LAST											
William						Whitehead		Elaine		Paradise											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS													
Yes		Viet Nam				219-40-6798		Patricia A. Whitehead				110 Hammershire Rd Reisterstown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF																					
(c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?											
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE			Marguerite Korell, M.D.							TITLE (SPECIFY) M.D.			Assistant				MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS							DATE SIGNED 6-16-87											
Marguerita A. Korell, M.D.			111 Penn Street																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial			June 18, 1987			Crest Lawn Mem. Gardens				Marriottsville, Howard, Md.											
24. FUNERAL DIRECTOR NAME			ADDRESS							25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
H. J. Ehland			Owings Mills, Md.							JUN 19 1987			Julia Darden-Randall								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please move carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23 is marked "Cremation", the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 7 1 7 5 6 0 REG. NO.			
4. DECEASED NAME (TYPE OR PRINT)			FIRST <i>EVA</i>	MIDDLE <i>E.</i>	LAST <i>ZELLNER</i>	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOURS 6-22-87 3:40 A.M.			
3. SEX <input checked="" type="checkbox"/> FEMALE			4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR <i>12 24 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN. <i>3 40 A.M.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PENNSYLVANIA</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard COUNTY MD</i>					
10. CITY OR TOWN OF DEATH <i>COLUMBIA</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOWARD COUNTY GENERAL HOSPITAL</i>		12a. USUAL OCCUPATION HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC				
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>HOWARD</i>	13c. CITY OR TOWN <i>COLUMBIA</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>6336 CEDAR LANE 21044</i>					
14. FATHER'S NAME FIRST <i>UNKNOWN</i>			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST <i>UNKNOWN</i>			MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>209-20-7767</i>		17. INFORMANT PEARL KELSHAW		18. ADDRESS <i>1139 VALLEY DRIVE PASADENA, MD 21122</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 → 60 mins.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>lymphoma</i>		(c)					<i>yes</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Shingles Coronary artery disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>6/19</i> , 19 <i>87</i> , to <i>6/22</i> , 19 <i>87</i> , that (I) (we) last saw the deceased <i>6/21</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE <i>Charles E. Sheehan, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <i>5/22/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles E. Sheehan, M.D.</i>		22e. ADDRESS HOWARD COUNTY GENERAL HOSPITAL		COLUMBIA MD 21044								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> BURIAL		23b. DATE <i>6/26/87</i>		23c. NAME OF CEMETERY OR CREMATORIAL CEMETERY TRANSFIGURATION R.C.		23d. LOCATION CITY OR TOWN <i>West Hazelton</i>		COUNTY <i>Luzerne</i>		STATE <i>Penna.</i>		
24. FUNERAL DIRECTOR NAME <i>Hubbard Funeral Home, Inc.</i>		ADDRESS <i>4107 Wilkens Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 26 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Scidmore Landes</i>						

home - no one who wanted

any

much for a country

and a good place

and a good place